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REPORT

ON

HEALTH CARE OF THE AGING VETERAN: A REPORT OF THE GERIATRICS AND GEREONTOLOGY ADVISORY COMMITTEE

PREPARED BY THE

VETERANS' ADMINISTRATION
(Pursuant to Public Law 96-330)

SUBMITTED TO THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

JULY 25, 1983

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JUN 30 1983

JUNE 28 1983

Honorable G.V. (Sonny) Montgomery
Chairman, Committee on
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House of Representatives
Washington, D.C. 20515

JUN 30 1983

Dear Mr. ~~Chairman~~ Sonny:

In accordance with the requirements of Public Law 96-330, I am forwarding to you the report, "Health Care of the Aging Veteran: A Report of the Geriatrics and Gerontology Advisory Committee." The report is the culmination of two years of work by the Geriatrics and Gerontology Advisory Committee (GGAC) and includes in the appendices an interim report on our Geriatric Research, Education and Clinical Centers (GRECC), submitted earlier this year.

The GGAC approached its tasks with interest and concern for the aging veteran population and their report has underscored our commitment to that special population. They have offered a document which is broad in scope, reflecting the challenges facing all of us who are committed to providing quality health care services for our Nation's veterans. Many of the recommendations may have far-reaching implications for humanistic care, not only for veterans, but for all older citizens. Each recommendation must be considered in a thorough, deliberative process by program planners and managers alike.

You may know that the Veterans Administration has an active planning effort for care of the aging veteran population which, in addition to other considerations, will address the GGAC recommendations. That effort will result, in the fall of this year, in a document outlining the Department of Medicine and Surgery's planned initiatives in the area of geriatrics. I anticipate that many of the issues which surface in our planning process will mirror those raised by the GGAC.

I appreciate the support expressed for our program efforts by the GGAC; however, their report reflects the Committee's observations at one point in time and must be viewed in that light. Our clinical programs are dynamic and have continued to evolve over the two year period during which the GGAC conducted its affairs and authored this report with its recommendations. Nonetheless, the report, coupled with our own initiatives and concerns, will enhance our future efforts for aging veterans.

Sincerely,

Harry

HARRY N. WALTERS
Administrator

Enclosure

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The Geriatrics and Gerontology Advisory Committee would like to acknowledge the staff of the Veterans Administration for their support and assistance.

The Committee is very appreciative of the receptivity that has come from both Central Office and field facilities. An extensive amount of data, program information and reports have been made available to the Committee.

Many Veterans Administration employees, professional staff, and administrators have provided significant assistance to the work of the Committee. A number of VA personnel have made specific contributions to this report. Others are acknowledged for their cooperation in arranging the site visits that were made to VA Medical Centers that host the Geriatric Research, Education and Clinical Centers. Additional medical centers have been helpful in facilitating general site visits which were made by individual Committee members.

Acknowledgement is made for the relevant data provided to the Committee by the National Center for Health Statistics and several other federal agencies. A special note of thanks is also extended to Edwin B. Hutchins, Ph.D., of the University of Pennsylvania for his contribution to this report.

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INTRODUCTION

The Veterans Administration Health-Care Amendments of 1980, Public Law 96-330, codified at 38 U.S.C. 4101 (f), was enacted by Congress on August 26, 1980. The stated purpose of Title III of that act, entitled "Geriatric Research and Care," Section 301, was "(1) to improve and expand the capability of the Veterans Administration health-care facilities to respond with the most effective and appropriate services possible to the medical, psychological and social needs of the increasing number of older veterans, and (2) to advance scientific knowledge regarding such needs and the methods of meeting them by facilitating higher quality geriatric care for eligible older veterans through geriatric and gerontological research, the training of health personnel in the provision of health care to older individuals, and the development of improved models of clinical services for eligible older veterans."

The stipulations of the law included the establishment of the Geriatrics and Gerontology Advisory Committee (GGAC). The Committee was to include individuals with interest and expertise in the area of aging who were not employed by the federal government. At least one member of the GGAC was to be a representative of a national veterans' service organization.

The GGAC was established in January 1981, with twelve members receiving official appointment in May 1981. Two additional members were appointed in October 1982. Members of the Committee were selected for their professional expertise, knowledge and experience in the field of geriatrics and gerontology. A list of members with short biographical sketches appears in Appendix A. A full curriculum vitae for each member is on file in the VA Department of Medicine and Surgery (DM&S).

Pertinent provisions of Section 302 are quoted below outlining the charge to the Committee:

(i) "advise the Chief Medical Director on all matters pertaining to geriatrics and gerontology;

(ii) "assess, through an evaluation process," the geriatric research, education and clinical centers;

(iii) "assess the capability of the Veterans' Administration to provide high quality" health-care services to eligible older veterans;

(iv) "assess the current and projected needs of eligible older veterans" for health-care services from the VA and its activities and plans to meet those needs; and

(v) "perform such additional functions as the Administrator or Chief Medical Director may direct."

The GGAC was directed to submit a report to the Administrator of Veterans Affairs, through the Chief Medical Director, regarding its findings and conclusions. The report was directed to be presented not later than April 1, 1983 and was to include:

- a description of the operations of the Geriatric Research, Education and Clinical Centers (GRECCs);
- an assessment of the quality of the operations of the GRECCs;
- an assessment of the extent to which the VA is meeting the needs of eligible older veterans for health-care services;
- assessment of deficiencies, and recommendations for correcting deficiencies in the operations of the GRECCs; and
- recommendations regarding other services which might be required to meet the needs of older veterans.

The Committee may also submit in the same manner any other reports that it considers appropriate to its charge.

In January 1983 the GGAC submitted an interim report to the Veterans Administration. That report was submitted in response to a Congressional request and contained the Committee's assessment of the GRECC Program. A copy of the report is in Appendix B. The body of this report will assess the older veterans' current and projected needs and will assess the capability of the VA to provide high quality care to these eligible older veterans. It will address the VA activities and plans designed to meet these needs. Furthermore, pursuant to the directives of the law, the report will review the health and care needs of aging veterans and will comment upon relevant research, and other activities related to the provision of services to the older veterans.

Chapter I

EXECUTIVE SUMMARY AND RECOMMENDATIONS

Planning for the health care of America's aging veterans is a task broader than estimating acute care needs. The quality of health care is integrally related to the quality of life itself. It is paradoxical that, having survived to old age through the auspices of quality care, the aging veteran becomes susceptible to an array of chronic illnesses. Under duress of these illnesses it is increasingly apparent that those individuals who can be actively maintained in their homes and communities are likely to be better sustained and enjoy a higher quality of life.

Thus attention is focused on a number of dominant themes that greatly affect projections of needed health care resources and any assessment of Veterans Administration (VA) response. One is the effort to turn the dominant direction of care toward the use of a wide array of chronic care and community resources. The goal is to maintain the highest level of independent functioning commensurate with the health and physical well being of the older citizen. The corollary objective of utilizing existing community resources and support systems to contain the costs of acute care is compatible with the primary goal.

The second dominant theme is that the World War II veteran receiving care in the VA system will contribute to the learning of a high proportion of the next generation of health care professionals. This then is an opportunity to alter the manner in which these professionals will provide care to older people in the future.

Another dominant theme is that our patterns of care delivery will be affected in the future, as they have in the past, by the unfolding of new knowledge. Biomedical research on both basic processes of aging and age related diseases will contribute to advanced modes of prevention and treatment. Health services research, attentive to the broad needs of the aging veteran, can serve to direct attention to needed changes in patterns of delivery and identify barriers to the delivery of quality care while helping to maximize the allocation of resources.

In accord with its mandate the Committee site visited each of the Geriatric Research, Education and Clinical Centers (GRECC) and submitted its evaluation report on the GRECCs to the Chief Medical Director on January 7, 1983 (Appendix B).

Members of the Committee also site visited other VA facilities that do not have GRECCs in reference to their clinical and research activities related to the older veteran. In addition, the Committee has reviewed in-depth the demographic changes occurring in the veteran population and the projected needs of this population, and has assessed the overall clinical, research and educational facilities within the VA that are available to meet these needs.

Within the next two decades the cohort of World War II veterans, now entering their early sixties, will present the Veterans Administration with a major challenge to the delivery of health care. In the 21st Century, the World War II cohort will be followed by aging Korean Conflict and Vietnam Era veterans. As individuals age in our society, there is a marked increase in the occurrence of chronic diseases including chronic heart and lung disease, the aftermath of stroke, hearing and visual impairments, periodontal diseases, dementing illness especially Alzheimer's Disease, Parkinsonism, senile macular degeneration, arthritis and bone disease and other disabling conditions. Alcoholism continues as a problem in the aging veteran. Thus the maintenance of health takes on an added dimension for this group and the projection of increased health care needs invites rather immediate planning if the VA is to respond fully to these needs.

On October 22, 1970 Public Law 87-583 was amended by enactment of P.L. 91-500 to include, resources permitting, "Eligibility for hospital, nursing home and domiciliary care" for "... any veteran for a nonservice-connected disability if such veteran is sixty-five years of age or older". This amendment can be found at 38 U.S.C. sec. 610 (a)(6). Currently 12% to 16% of veterans avail themselves of this entitlement depending on the type of care and the age of the veteran. If this percentage continues to seek medical care in the mode it is now delivered then by the year 2000 the VA would require a major expansion of its existing hospital system. Unless other alternatives are found additional extended care beds will be needed to provide the same proportion of care as now given. The percentage seeking VA help may be further increased as Medicare benefits are restricted and if nursing home care were to be paid only by Medicaid. Projections of needed services and resources can also be expected to increase under conditions of general economic adversity. Decisions as to entitlement and resources therefore become primary issues to be decided by Congress and the President.

Within the administration of the VA there is an urgent need to act in order to rationalize long-term care for chronic diseases. This will require adjustments of administrative practices, development of new models for care of the aging veteran, and expansion of health services research to develop and evaluate such models. Education of health professionals in geriatrics and gerontology is a high priority, including strengthening the current VA Geriatric Fellowship Program which serves as an excellent example of initiative in this area. Increased support for biomedical research directed to basic aging processes and diseases of aging is needed, including, but not confined to, further development of the GRECCs.

Overall the Committee was impressed by the enthusiasm and dedication of the scientific and professional staffs of the GRECCs and by a growing interest throughout the VA in developing improved care for the aging veteran with chronic disease. The initiation of additional educational and research efforts were evident in the staffs of several of the VA hospitals visited which did not have GRECCS. Moreover, it is apparent that the VA Central Office is aware of the impact of the aging veteran population and is actively engaged in extending its planning and programming to accommodate the derivative needs. The VA has within its present infrastructure the nuclei of programs which, if developed fully and appropriately, can lead to the establishment of a rational system of care designed to serve the needs of the aging veteran. Further, it has the potential to serve as an exemplary model for the nation and as a geriatric training site for future health professionals.

The present report, together with the appended report on the GRECCs fulfills the initial mandate of the Committee. The Committee's recommendations are presented first, organized within a clinical, education and research framework, with no priority implied. The body of the report and the appendices follow the recommendations.

Clinical Care Recommendations

1. Given the imperative nature of the aging veteran's health care needs, priority should be given to the planning of a progressive care delivery system to fit the needs of the rapidly expanding aging veteran population.

The criteria of availability, accessibility, comprehensiveness and continuity of care can best be met in the near future by developing a system of entry that guarantees access to the system for the aged veteran. This focal point for assessment and care management will serve to coordinate services, including a full range of community based services and funding sources, and will serve to guarantee comprehensiveness and continuity of care. The complex package of services required by elderly veterans with chronic disabilities should encompass their psychosocial, economic and personal problems as well as their medical problems. Critical to the success of this recommendation will be the use of a case tracking management approach in which continuous responsibility for the veteran's interaction with the system is fixed with a specific health professional or a health profession team.

2. The VA should institute a policy requiring that a veteran patient first be assessed by geriatric trained providers in a VA Geriatric Evaluation Unit as a precondition to admission to a nursing home or other long-term care facility. To further support and enhance the essence of this recommendation, an indepth study of admission, transfer and discharge across all levels of care should be undertaken. The study should address such issues as the barriers to transition across levels of care, models assuring continuity of care through transitional phases, and the impact of current policies and procedures on costs of care, on timeliness of care, and on quality of care for the aging veteran.

3. In the effort to rationalize the system of care for the aging veteran serious attention must be paid to the barriers to care and the disincentives that exist to frustrate delivery of optimal care. These barriers are legislative, administrative, financial and professional. There is need for an indepth study of the interactive effects of entitlements, eligibility, incentives, and resource allocation on the delivery and cost of care at various levels of care as these pertain to the aging veteran. The study should consider regulations that cause use of more costly care and barriers to use of support services for elderly veterans that might serve to prevent institutionalization.

4. There is need to accelerate reallocation of acute care resources from areas which are declining in need to the development of resources for delivery of chronic care.

The current administrative procedure of allocating budgets for VA Medical Center (VAMC) operating funds on the average daily census of occupied beds appears to act as a disincentive to efficiency. Moreover, this encouragement of unnecessary hospitalization or extended length of stay tends to discourage alternative models of geriatric health care that do not emphasize hospital bed utilization.

5. Innovative models of care delivery represent a particularly important area for careful development and evaluation. The VA should undertake and provide for the development, demonstration and independent evaluation of innovative models. While specific models of care may not be applicable in every VAMC, certain principles are becoming evident with regard to the maintenance of veterans within their home and community, maximizing family capacity and informal supports, and the inclusion of social modes of intervention along with comprehensive medical care.

While not a complete list of alternatives, specific models of geriatric care to be considered for inclusion in this effort for development or expansion and evaluation include:

Geriatric evaluation units (GEUs) prior to long-term care
Satellite (cottage) hospital care such as in the United Kingdom program
Satellite outpatient clinics
Hospital based home care
Respite care
Hospice care
Day programs
Case management and tracking
Residential (foster) home care
Education and guidance for families in rendering care
Nursing homes without walls such as the pilot program in New York State
Integration of VA medical care activities with community resources
Innovative programs to meet special needs of institutionalized patients with dementia.

Certain of these models exist to some degree within the VA health care program and several medical centers have shown promising situations. All of the models are in need of scientific evaluation. The Committee believes there is a special timeliness to this effort and that the VA has a unique opportunity and indeed, with the clear increase in older veterans and the societal mandate to provide for their health care, the responsibility to develop and evaluate new models of geriatric care.

6. Projects that link and coordinate VA and non-VA resources for the aged veteran need to be developed and evaluated. Such special projects may need new legislative authority that would enable the development and evaluation of VA and community resources in demonstration projects. Such projects could include the coordination of VA services, pensions and compensation and non-VA resource and benefits available for aging veterans.

7. Where developmental efforts are limited by current legislative authority, for example in developing integration between the VA and community resources (Recommendation 6), the Committee recommends that the Congress enact such statutory changes as may be necessary to enable implementation and evaluation of these innovative models of care. The Committee believes the pursuit of these efforts will be efficient and cost-effective in providing quality care to the older veteran.

8. A rehabilitative approach should be an integral part of all care plans for frail older persons, aimed at restoring and/or maintaining function and as much independence as possible. Much more needs to be learned and put into practice in this field. Important examples of developmental efforts which should be supported by the VA include:

a) An extension of the effective research and development already accomplished by the VA in rehabilitation of younger spinal cord injury patients, to older veterans with similar problems, such as management of urinary incontinence,

b) the special attention that should be given to rehabilitation of sight and hearing. Loss of sight and deafness are very common problems in older persons. Efforts in this area can be substantially increased in view of rapid developments in technology, for example, computer-generated voice technology,

c) the preventive and rehabilitative treatment of alcoholism in older veterans, increasingly recognized as a problem in the VA health care system,

d) the rehabilitation of veterans with strokes, Parkinson's disease and other neurological disorders; maintenance of function as long as possible for veterans with Alzheimer's Disease and other dementias, and

e) the rehabilitation treatment of common musculo-skeletal disorders of older persons, for example, osteoarthritis and osteoporosis.

Recommendations for the Education of Health Professionals

1. Of equivalent priority are those educational programs that can appropriately and immediately prepare personnel for the many needed roles in geriatric care. High priority should be given to incorporation of geriatric training in the present system of VA residencies. By mandating that geriatric experience in every specialty become an integral part of all residency training supported by VA, the education of future physicians can be affected in a manner not likely to ensue if the present system of graduate medical education is left to its own devices. There should be a similar mandate for the inclusion of geriatric training in VA supported educational programs in nursing, dentistry and allied health.

2. The VA Department of Medicine and Surgery (DM&S) should move to review and restructure the nature of affiliations with professional schools. While the affiliations with medical schools have served to enhance the quality of acute care for the American veteran over the past 35 years, it is critical that nursing and nursing education be given an increased role and comparable opportunity to enhance the quality of care in the VA as it develops advanced models of care to serve the geriatric population. Here the emphasis must be on the continuity of care. This emphasis is in response to a segmented and specialized acute care delivery system that is too frequently found to be antithetical to the needs of the aging veteran. The concepts of interdisciplinary teams, teaching nursing homes, and a comprehensive care center

could serve well as stimuli to develop such integrative models of care. The nursing home as a sole focus is limited as an overall integrative model for care and as a locus for education of health care professionals. Too often, as presently constituted, it becomes a negative reinforcer for entry level professionals who might otherwise consider a career in geriatrics. It's essential, therefore, that the VA develop affiliation agreements with schools of nursing in the same manner as they have with schools of medicine.

3. Greater support, including support for program faculty and for research resources for trainees, should be allocated to physician and dentist geriatric fellowships, interdisciplinary team training in geriatrics, and nursing scholarships for geriatric training. One approach would be to begin an immediate review of support for residency training in specialties soon to be in surplus and how this might be redirected to training programs relevant to geriatrics. An important elaboration would be the inclusion of doctorally prepared nurses in the Geriatric Fellowship Program.

In support of the recommendation to require assessment in a Geriatric Evaluation Unit as a precondition to admission to long term care, the Geriatric Fellowship Program should be substantially expanded. This should be at a pace commensurate with the high quality of the present program while recognizing the immediacy of the needs. It is further recommended that within the next two years the number of sites should be increased from the current 12 to as many as 24 and the number of fellows accepted at each site yearly should be increased from 2 to 4. This will, in a period of two years, increase the annual production of fellows from 24 to 96. It would be advantageous within three years to increase the number of sites to 36 with each accommodating 6 fellows to produce a flow of some 200 fellows per year. If 50% of these move into staff positions in Geriatric Evaluation units, the VA can anticipate that these units will be well staffed by 1990 when the service demands of the World War II veterans will become acute. In contrast to the 7,700 residencies in acute care medicine now being supported by the VA, this would seem to be a modest investment in preparation of leadership for geriatric care. Similar consideration should be given to expansion of the geriatric fellowship program for dentists.

4. Efforts should be made to increase the proportions of internists and various medical and surgical specialists who develop primary and secondary research programs in aging. Such efforts would contribute substantially to the national need for more geriatrically-oriented clinical research. In addition an effort should be made to increase the proportions of biochemists and other basic scientists with major commitments to aging, as new molecular and cellular knowledge of the basic aging process could lead to the prevention or amelioration of various age-related disabilities and diseases.

Research Recommendations

Health Services Research

1. While the promise of basic biomedical research cannot be denied, the present cohort of World War II veterans will live out their lives in the near future. The second wave of older veterans, the Korean Conflict and Vietnam Era veterans, are the ones most likely to benefit ultimately from the full range of activity

in health care, education and research. A high priority should be placed on health services research. Sound data here can also help to focus the attention of the biomedical research community on salient problems related to the processes of aging.

2. Through the focusing of resources within and outside the network of GRECCs, the VA should encourage the development of health services research relevant to forecasting, pilot projects, delivery, and evaluation and costing of the process of caring for the aging veteran. In this regard, it is especially critical that the VA Central Office develop the capability within its administrative structure to generate data for the conduct of reliable and valid comparative cost studies.

3. A research enterprise, particularly if modest in size, should be organized to generate an integrated body of knowledge. As the aging American veteran becomes less able to cope with the segmented and specialized structure of the medical care system, and thus becomes more vulnerable to increasing complications from multiple chronic disease entities, the need for cost effectiveness and efficiency in the VA medical care system increases.

4. In view of the limited budget for health services research, which amounts to .00037 percent of the DM&S medical care budget, and the likelihood of increasing problems in delivering health care to the aging veteran population, the Committee recommends that the budget for health services research should be substantially increased.

5. In order to aid in the attempt to develop a more focused body of knowledge from the VA health services research efforts, the Committee recommends that VA health services research should focus the majority of its efforts on the efficiency, effectiveness, and organization of services provided to the aged veteran population. Priority areas of inquiry should include: a) clinical decision making, b) innovative models of care delivery, and c) the coordination of VA and community resources.

> a) Clinical decision making projects would focus on the efficiency and cost effectiveness of alternative courses of treatments or therapy, diagnostic techniques and patient management protocols. Studies in this priority area would also include clinical questions regarding the management of patients with Alzheimer's disease or other organic brain diagnotic categories, problems of drug utilization patterns such as the drug-drug interactions of polypharmacy, and the cost effectiveness of preventive and health maintenance regimes in the aged population.
>
> b) The innovative models of care delivery listed under clinical care recommendations should be evaluated using well designed health services research studies.
>
> c) Projects that link and coordinate VA and non-VA resources for the aged veteran need to be developed and evaluated. Such projects could include the coordination of VA service benefits and non-VA reimbursement benefits for eligible aging veterans.

6. The committee views the quality and quantity of the VA health services research effort to be generally inadequate, particularly in view of the likelihood of increasing health care delivery demands by the aging veterans. Accordingly, there is a pressing need to develop a greater capacity within the VA research program to perform high quality health services research. To this end the Committee recommends four strategies for improving the quality of health services research:

a) implementing the P.L. 96-330 mandate to attract scientists who are capable of evaluations of the activities of the GRECC program and other innovative models of care delivery,

b) instituting a Career Development Award for VA investigators in health services research,

c) supporting physicians, dentists, nurses and other VA health care providers in health services research training programs within affiliated educational institutions, and

d) including a significant education component in the six newly developed Health Services Research Field Programs.

7. The Committee recommends that a Merit Review Board for Health Services Research, comparable to those established for the review of biomedical research grants, should be developed, and that investigator initiated proposals, including cooperative studies, should be encouraged.

Rehabilitation Research

1. Research on the psychological aspects of and psychotherapeutic contributions to rehabilitation, for example, studies of motivation, sexual problems, or behavioral therapy, can all make significant contributions to the total understanding of the rehabilitative process.

2. Further research on the team approach to rehabilitation and its application throughout care settings for older veterans is essential. Of paramount importance to this development will be well designed and adequately supported evaluation studies of the efficacy of the team approach in rehabilitation.

3. Clinical studies on restoration of sight and hearing, and on rehabilitative treatment of neurological disorders, musculo-skeletal disorders, and alcoholism are essential to progress in the care of the aging veteran.

Biomedical and Psychosocial Research

1. The new program of research grants for promising innovative research on basic biochemical and physiological mechanisms underlying aging should be continued. Especially attractive is the goal of attracting outstanding investigators who have not previously worked in the field but who may conceive of entirely novel approaches. It is highly desirable, however, that sufficient funds become available to support a larger proportion of the meritorious grants than is presently envisaged. At present, only a few proposals can be funded. More than 350 letters of intent have been received, perhaps half of which could meet the standards of the ad hoc merit review board. There is, therefore, a

growing perception among VA investigators that the probability of obtaining funds is so small that their research efforts might be more productively channeled in other directions. The program is of sufficient importance to warrant budgeting as a line item to protect and enhance its position.

2. An excellent start has been made in encouraging research in Senile Dementia of the Alzheimer Type (SDAT) and related problems of aging in the central nervous system. Every effort should be made to maintain and enhance research on these disorders, which the Committee believes warrants the single highest priority for the biomedical, psychosocial and health services research dollar, both because of the dehumanizing nature of that category of illness and because of the enormous and ever-increasing economic burden attributable to such disorders, in particular, the requirement for long-term care.

3. More basic research is needed that is relevant to the extremely important problem of why aging mammalian species, including man, exhibit exponential increases, beginning after middle age, in the frequencies of many types of cancer.

4. Progress on the psychosocial aspects of aging processes would be accelerated if there were mechanisms to more readily permit VA employment of social and behavioral scientists whose principal training was as an investigator rather than as a clinician.

General Research Recommendations

1. The Committee reaffirms the conclusions and recommendations of the 1977 review of Biomedical Research in the Veterans Administration carried out by the Cluff Committee, Division of Medical Science, National Research Council, both in reference to the overall research program and, in the present context, in reference to the program of research on aging. The latter can only thrive in proportion to the excellence of the overall research program, since the problems of aging interrelate with virtually every aspect of biomedical, psychosocial, health services and rehabilitation research.

The National Research Council recommended "unanimously and enthusiastically" that there be continued and vigorous support of the independent funding in the VA of an intramural research program because:

a) "The VA offers a unique opportunity to carry out a wide variety of clinical studies involving a distinct patient population in a large number of hospitals under a single management.

b) "A high quality research program with its attendant focus on inquiry and creativity fosters an environment conducive to professional excellence in health care delivery.

c) "The overall national biomedical research effort will be more effective if a pluralistic system of funding is maintained. Such a system prevents any single agency from monopolizing the nature and direction of research." (Cluff, 1-1).

2. As a percent of the total budget for medical care, the R&D budget decreased steadily from 4.0% in 1970 to 2.20% in FY 1979 and to 1.92% in FY 1982. It is estimated to be only 1.95% in FY 1983. Considering the great potential of

research and development for revolutionizing patterns of patient care - indeed, in some instances (for example, poliomyelitis) for obviating almost entirely the need for patient care, this appears to be an astonishingly low figure and should be steadily increased so as to approach at least 5% of the total budget for medical care. Since the dollar amounts for research do not reflect the bulk of the salaries for VA staff engaged primarily in patient care, more precise mechanisms for estimating the full-time equivalents of such research personnel are required to obtain a more complete accounting of the VA research budget.

3. It is important to establish the concept that the opportunity to devote a limited proportion (generally between 20-25%) of a health professional's activities to a program of health sciences research, is a bona fide part of his or her job description, even when the primary duties clearly involve patient and related services. The Committee believes that providing a climate for research is a prerequisite for creating an environment capable of attracting and maintaining high calibre professionals able to develop cost-effective innovations in patient management.

4. Since the program of research career development within the VA has been exceedingly successful, having supported, for example, five winners of Lasker awards and two Nobel laureates in medicine, the erosion of support for that program in recent years is of great concern to the Committee and to researchers within the VA system. We recommend increments in that program to recoup those real dollars lost to inflation and to restore growth.

5. The Committee concurs with the statements of the National Research Council report of 1977 concerning the outstanding record of achievement and continued potential of the Cooperative Studies Research Program of the VA, particularly as regards clinical research and clinical trials. This proven system of collaborative research among many facilities involving large numbers of patients is highly relevant to geriatrics and special efforts should be made to encourage such research.

6. The Committee recommends that one gerontologist or geriatrician with expertise in the relevant disciplines be appointed to each of the 14 Merit Review Boards of Medical Research Service in order to assess those aspects of the proposals that require special knowledge of issues in gerontology and geriatrics. Although an ad-hoc committee of distinguished gerontologists has recently been formed by the VA for the purpose of reviewing applications for the new granting program on innovative basic research, there is no standing Merit Review Board to consider all applications for research in aging. The Committee considered this option, but rejected it, for the present, in favor of continued responsibility for the review of scientific merit by the 14 existing discipline-oriented Merit Review Boards.

7. The Committee recommends a re-evaluation of the policy of sharply differentiating between research projects and programs, of not permitting an investigator to entertain more than one program, and of terminating, simultaneously, all research projects within one program.

8. The evaluation of the VA biomedical research program was compromised by the limited data available at VACO on the quantity and quality of aging research. While individual research projects are carefully reviewed by Merit Review Boards, there appears to be no systematic program of data analysis and, therefore, strategic planning within the Office of Research and Development is

compromised. Budgetary limitations on the number of suitably trained personnel to implement such a program may be one reason for this deficiency. The Committee recommends the establishment of a unit of strategic planning to coordinate research programs, to evaluate ongoing research and to help develop new research directions based upon sound rationales.

Recommendations Regarding the Geriatric Research, Education and Clinical Center Program

Established with the purpose of integrating within the field of geriatrics the three areas of clinical care, education of health professionals, and research, the GRECC program has now been in existence a sufficient period of time to warrant the review undertaken by this Committee. The Committee reaffirms its conclusions and recommendations relative to the activities of the GRECCs as given in the interim report of January, 1983 (Appendix B). The original five recommendations are presented below with an additional recommendation regarding priority research funding.

1. DM&S should re-examine the expectations and limitations affecting the GRECCs and host facilities as set forth in P.L. 96-330. If GRECCs are aggressively and equally to undertake research, education and clinical care, greater resources will be necessary. If a GRECC may be allowed to emphasize one or two of the components, the original structure may suffice. If necessary, DM&S should recommend a change in the law in order to reconcile the limited resources with realistic objectives.

2. More effective evaluation of the GRECC activities should be instituted both in the GRECCs themselves and in Central Office. The Central Office should establish a locus for leadership responsibility for the GRECCs. Administrative plans and procedures should be developed for an ongoing evaluation of the GRECC program. The VA should have in place a GRECC Evaluation Committee that includes non-VA members. Included in a periodic review should be a consideration of the merit of each research project, the research program as a whole, as well as the education and clinical components. Mechanisms should be established to assure that the deficiencies are corrected.

3. Research funding for the VA should not be diminished. Research in the GRECCs can only prosper to the extent that research funds are adequate for the VA's research program in general. Appropriate administrative funds should accompany incremental research funding to the GRECCs.

4. Health services research should be initiated to include the study of innovative models of care, including an evaluation of their cost effectiveness. To accomplish this and to meet other needs, it is necessary to train and recruit nurse investigators and other health professionals.

5. It is recommended that the VA develop a standard accounting procedure and report for designated GRECC funds. The annual report is to be prepared by the host facility of a GRECC and transmitted to the Central VA Office.

6. To maximize the number of investigations in aging within the VA, and to maximize the likelihood of top quality research, it is recommended that principal investigators within a GRECC should not be limited to a proposal

related to the theme of that particular GRECC and that applications for cost center 106G funds be permitted to come from any qualified investigator within the VA system, and not only, as is now the case, from investigators associated with a GRECC. Such a development should be accompanied by a more sharply defined set of criteria for what type of research in fact would qualify for 106G funds.

CHAPTER II

DEMOGRAPHICS OF THE AGING VETERAN

The implications of a number of demographic determinants are clear in broad outline. In short, more people will be living longer and as this aging population expands, the character and pattern of illness, as we now know it, will be dramatically altered with an ever higher fraction of total health care needs falling in the realm of chronic illness.

In the section that follows, data relevant to the aging veteran will be presented in an effort to: (a) identify the growing needs of this special group in our society; (b) offer a perspective on the aging veteran as a critical part of the broader health care scene; (c) describe the programs that the VA DM&S has undertaken to serve the needs of this population; and (d) understand the unique role the veteran has played in the past in health professions education and can play in the future in the preparation of providers for geriatric health care. In the following section the geriatric imperative for the population of American veterans is made clear through the demographic data now being routinely analyzed by the Census Bureau, the Nrtional Center for Health Statistics, and the VA Central Office.

Because the status of veteran has been achieved by most American males during periods of armed conflict, the distribution of veterans according to age is not even. The three concentrations in the age distribution are those related to the large number of World War II veterans, to a limited extent to those that were engaged in the Korean conflict, and then again to a large number that served during the Vietnam era (Figure 1). In 1982 the total number of veterans in the United States and Puerto Rico was 28,522,000. Of these, 24,262,000 were war veterans, and of the war veterans some 11,268,000 served during World War II (Veteran Population, 1982). Proportionately, World War II veterans represent the largest single cohort of all living veterans in the country, comprising 40% of the total. Table 1 presents the breakdown by period of service and by age. Of the total 28 million veterans, 3 1/2 million are at the present time more than 65 years of age. Within five years this number will exceed 7 million and by the year 1990 the number of veterans over 65 will be in excess of 9 million. Without further consideration, these statistics are compelling in and of themselves. Within five years the number of aging veterans will double; within ten years it will nearly triple. How the VA can prepare for such a dramatic change in the character of its prospective patient population must be a matter of immediate concern to anyone in any way related to this issue.

Veterans accounted for 12 1/2% of the civilian population at the end of 1982. However, the proportion of veterans in the upper age ranges will dramatically increase in the immediate future. While today only one of every eight Americans is a veteran, the proportion of United States males who are 65 and over and are also veterans is now approximately one out of three. By the year 2000 this proportion will reverse and the proportion of aging veterans will then be two out of every three males over 65 (Figure 2). There will then be a slight decrease in the total number of aging veterans following the year 2000, with a subsequent increase again around 2010 as the Vietnam cohort enters the upper age range (Figure 3).

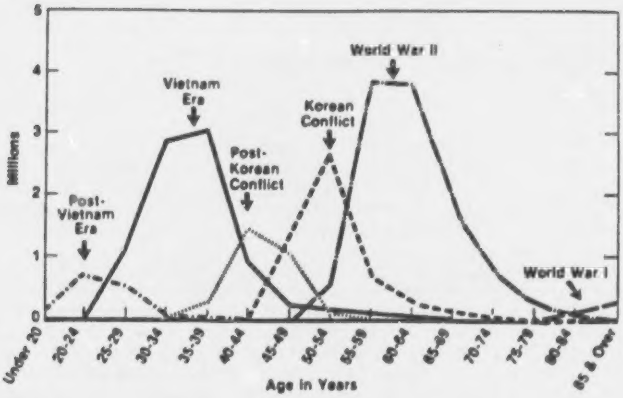

Figure 1. The Aging Veteran Population. September 30, 1982

Source: *Veteran Population, September 30, 1982*, Office of Reports and Statistics, Research Division, Veterans Administration, December 1982.

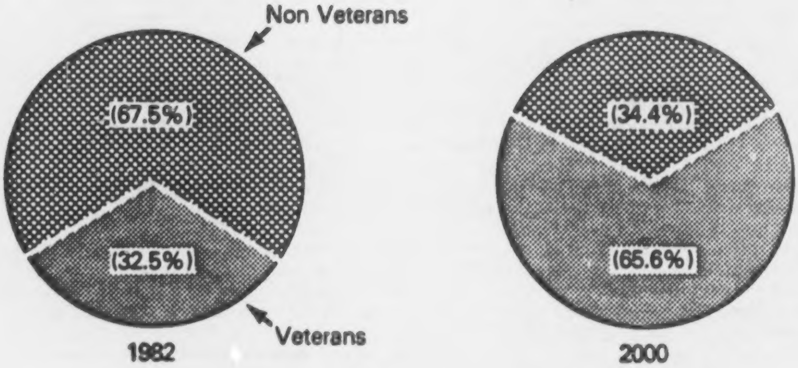

Figure 2. Percent of U.S. Males 65 and Over Who are Veterans

Source: Office of Reports & Statistics, Research Division, Veterans Administration, 1982.

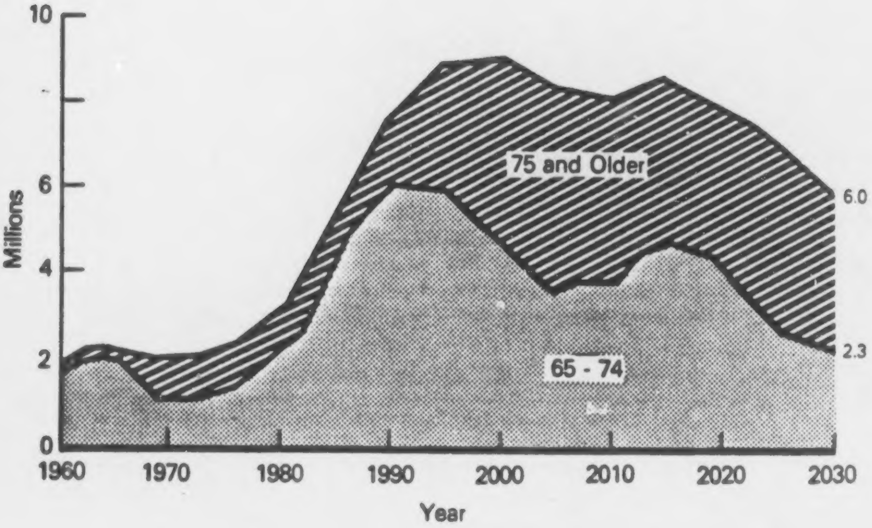

Figure 3. Number of Veterans Age 65 and Over

Source: Office of Reports & Statistics, Research Division, Veterans Administration, 1982.

Table 1 ESTIMATED NUMBER OF VETERANS LIVING IN THE U.S. AND PUERTO RICO, BY AGE AND PERIOD OF SERVICE
SEPTEMBER 30, 1982

(In thousands)

Age	Total Veterans	WAR VETERANS								Post-Vietnam Era 4/	Service Between Korean Conflict and Vietnam Era Only
		Total 1/	Vietnam Era		Korean Conflict		World War II 3/	World War 1			
			Total 2/	No Service in Korean Conflict	Total 2/ 3/	No Service in World War II					
All Ages	28,522#	24,262#	8,708	8,188	5,421	4,338	11,368	368		1,372	2,888
Under 20 years	9	-	-	-	-	-	-	-		9	-
20-24 years	735	12	12	12	-	-	-	-		723	-
25-29 years	1,718	1,162	1,162	1,162	-	-	-	-		556	-
30-34 years	2,890	2,818	2,818	2,818	-	-	-	-		72	-
35-39 years	3,364	3,084	3,084	3,084	-	-	-	-		11	269
40-44 years	2,465	951	944	941	10	10	-	-		1	1,511
45-49 years	2,538	1,527	260	137	1,390	1,390	-	-		*	1,011
50-54 years	3,326	3,241	215	23	2,781	2,624	594	-		-	85
55-59 years	4,133	4,125	115	7	703	274	3,844	-		-	8
60-64 years	3,838	3,836	65	3	336	28	3,805	-		-	2
65-69 years	1,917	1,917	27	1	136	11	1,905	-		-	-
70-74 years	836	836	6	*	46	1	835	-		-	-
75-79 years	301	301	*	-	14	*	301	-		-	-
80-84 years	149	149	-	-	4	-	74	75		-	-
85 years and over	303	303	-	-	1	-	10	293		-	-
Median age 5/	50.8	54.0	35.6	35.2	52.4	51.5	61.6	87.3		24.7	43.9

NOTE: Excludes an estimated 127 (thousands who served only between World War I and World II, all of whom are 70 years of age or older and 235 (thousands who served only between World War II and the Korean Conflict, all of whom are 45-49 years of age. Also excluded are a small undetermined number of National Guard personel or reservists who in current service connected disabilities while on an initial tour of active duty for training only

[1] Veterans who served in both World War II and the Korean Conflict, or in both the Korean Conflict and the Vietnam era, are counted only once.

[2] Includes 520 (thousand) who served in both the Korean Conflict and the Vietnam era.

[3] Includes 1,083 (thousand) who served in both World War II and the Korean Conflict.

[4] Service only after May 7, 1975.

[5] Computed from data by five-year age groups

There are also 58 living Spanish-American War veterans whose median age is 102 years.

* Less than 0.5 (thousand)

Because the American population lives longer, it is important to further refine analyses of the elderly population by age categories 65-74, 75-84, and 85 and above. Here too marked changes can be anticipated as we progress through the next two decades. At the present time, the majority of aging veterans are in the 65-74 age bracket. By 1990 the proportion in the 75-84 age bracket will be appreciable, although the 85 and over category will shrink. By the year 2000 those in the 65-74 category will be considerably less, but the 75-84 category will then be significant. By the turn of the century, some 3 1/2 million veterans will be in the 75-84 category, another half-million in the 85 and over age range (Figure 4). Health care needs will follow these distinctions. The utilization of health services is, in general, age correlated in the upper age range, with the 85 and above group representing a marked increase in total utilization of services.

In viewing the veteran population in relation to the total population, other demographic variables are of interest as well. There is, for example, variation in the total number of veterans residing within a state and in the veteran-population ratio by state. Monitoring these data will be critical to the planning process to account for migration of aging veterans from one area to another. Among the states having the largest number of veterans are obviously those which are most populous. California has 3,088,000 veterans followed by New York with nearly 2 million. Texas has 1.7 million veterans, the states of Pennsylvania and Florida have 1.5 million each, and Ohio, Illinois and Michigan follow with respectively, 1.4, 1.3, and 1.1 million. The percentage these veterans represent of the total population range from a low in Mississippi of 9.6% to a high in Nevada of 15.6%. Other states with a high density of veterans are Oregon (15.1%), Florida (14.5%), Arizona (14.4%), and Maine and New Hampshire (each with 14.1%). While some of the high density states have in common being attractive living areas, there is nothing by way of geographic location that makes them unique, since all regions of the country have states of both high and low density.

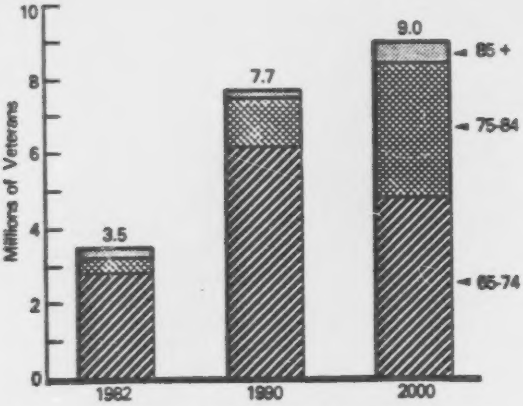

Figure 4. Veterans Age 65 and Over, End of FY 1982 and Projected to 1990 and 2000

Source: Office of Reports and Statistics, Research Division, Veterans Administration, 1982.

Though the veteran population has historically been comprised almost exclusively of males, today approximately 3% of ex-service personnel are women, and this proportion is growing rapidly. In 1981 the total number of female veterans was 742,000 doubling the number of a decade earlier. The high proportion of these tend to be in the younger age range and those in the upper age ranges are relatively similar in proportion to their male counterparts (Figure 5). Given the relative longevity of women, the sex distinction is likely to take on more significance for health care delivery as the increasing number of female veterans move into the upper age ranges. At the present time this cohort has not been as intensively studied as the needs of the future might indicate.

An important determinant of the use of the Veterans Administration health care services is that of eligibility. The key federal statute defining veterans' entitlements to health care is Section 4101 of Title 38, U.S.C. which provides that...

> "the primary functions of the Department of Medicine and Surgery shall be to provide a complete medical and hospital service...for the medical care and treatment of veterans."

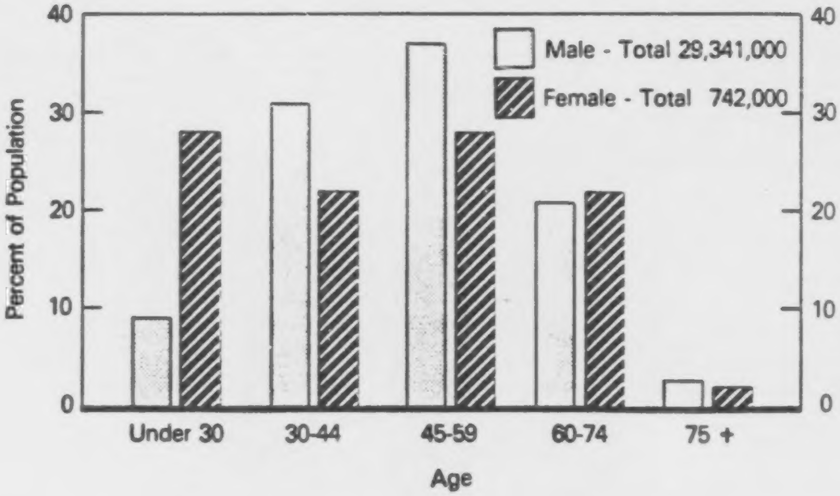

Figure 5. Estimated Male and Female Veteran Populations, By Age, September 30, 1981

Source: *The Female Veteran Population: An Overview of its Growth in the Last Decade*, Office of Reports and Statistics, Research Division, Veterans Administration, March 1982.

Other laws further define veteran eligibility for medical care. Having developed in a piecemeal fashion over many sessions of the Congress, these represent a complicated set of relationships that may at times inadvertently preclude care to a veteran, compromise the quality of care, or increase the cost of the care that is delivered. This may more often be the case in the care of the aging veteran who may need transition through various levels of care due to the chronic nature of his illness and thereby more frequently be confronted with the procedural complexities of the system.

Of some three dozen relevant pieces of legislation, one stands out in particular. P.L. 91-500, enacted October 22, 1970, amended P.L. 87-583 by authorizing care for nonservice-connected disabilities for veterans aged 65 or over without regard to their ability to defray expenses of such care to the extent that resources are available. By the year 2000 this will effectively place an umbrella of coverage over some 32% of all veterans (those over 65) and two-thirds of all aging males in the society, without regard to other previously mandated eligibility statements. However, even at this point in time there are limitations in some VAMCs and it has been reported that some veterans over 65 are unable to receive the full range of services they require when they seek care. The potential impact this will have on demand for Veterans Administration services, chronic and acute care alike, should not be underestimated.

The VA system is only one of several resources employed by American veterans to serve their health care needs. Insurance coverage is an additional parameter affecting the capability of the VA to respond to the likely demand for services by older veterans. Lawson analyzed health insurance coverage based on a 1977 survey of non-institutionalized veteran and civilian samples. Four types of coverage were identified:

> "Type 1: Private insurance only or private insurance combined with other insurance (excluding Medicare and Medicaid);
> Type 2: Medicare coverage only or Medicare combined with private or other insurance (excluding Medicaid);
> Type 3: Other public insurance only, including Medicaid, CHAMPUS, and CHAMPVA, but excluding Medicare.
> Type 4: No insurance."

The frequency and percent of veterans falling under these four types of coverage are presented in Table 2. While only one out of nine veterans are without insurance coverage compared to one out of seven of other adult males, similar coverage is achieved as both groups pass age 65 and become eligible for Medicare, Medicaid or other public insurance. For the older male veteran, one in eighteen are without health insurance coverage whereas only one in 24 other adult males have no insurance. Of the older veterans, four out of five (81.1%) are covered by Medicare. This implies that for most older veterans their use of VA health services is not directly contingent on those entitlements specified in P.L. 91-500. In fact, the overall proportion of services delivered by VAMCs, reflects useage by individuals who do not have insurance coverage.

TABLE 2

Types of health insurance coverage of male veterans and other adult males: Percentage distribution for selected characteristics.*

	Age				
	20-25 years	26-45 years	46-64 years	65 or older	Total
Number of Persons (in thousands)					
Veterans	1,147	11,576	12,144	2,419	28.295
Others	8,851	14,142	7,606	6,705	37,303
Private insurance only or private with other insurance excluding Medicare and Medicaid (Type 1)					
Veterans	56.2%	84.8%	82.1%	8.4%	75.6%
Others	71.6%	77.7%	76.3%	9.0%	63.6%
Medicare only or Medicare with private or other insurance excluding Medicaid (Type 2)					
Veterans	0.6%	0.7%	4.2%	81.1%	9.4%
Others	0.2%	0.9%	6.9%	78.7%	15.9%
Other public insurance only including Medicaid, CHAMPUS, and CHAMPVA, but excluding Medicare (Type 3)					
Veterans	8.7%	0.9%	4.0%	4.9%	3.9%
Others	4.2%	3.2%	4.7%	8.1%	6.0%
No insurance (Type 4)					
Veterans	34.6%	11.3%	9.8%	5.6%	11.1%
Others	24.0%	14.6%	12.2%	4.2%	4.5%

*Adapted from Lawson, Walter R., Jr., Health Insurance Coverage of Veterans. Washington, DC: National Center for Health Services Research, September, 1980, p.2.

Of related significance is the comparison of Veterans Administration hospital discharge data by income level (Figure 6). The inverse relationship between income and utilization makes clear the role that the VA plays as a "safety net" for those veterans who are not full participants in the social system. Those veterans with incomes less than $4,000 are four or five times more likely to use VA services than those earning $10,000 or more. (Seiling and Page, 1980) However, it is quite possible that expensive and extensive medical costs will drive other veteran nonusers into the system and the relationship presented in Figure 6 may be altered. For Medicare coverage, for example, there are limits that could ultimately contribute to a sharp increase in VA utilization by veterans who are currently nonusers.

Here, then, is the first, and perhaps most difficult, question in any attempt to forecast the health care needs of the aging veteran to be served by the VA: To what extent will the demand for VA health care services by the aging veteran be contingent on the general economy of the country and the related level of entitlements supported through other social programs such as Medicare? Other considerations relevant to the task of forecasting health services utilization will be identified in subsequent sections of this report.

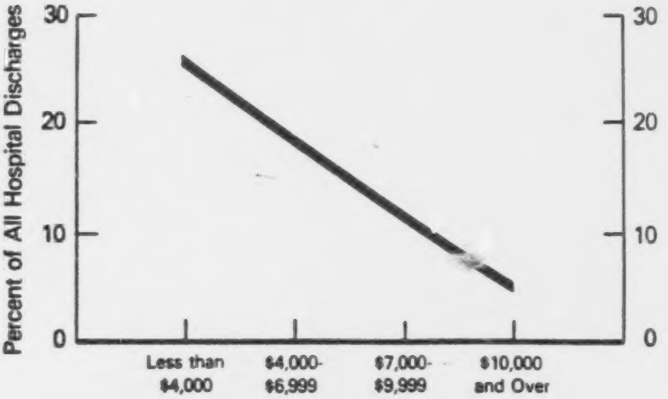

Figure 6. VA's Market Share of Hospitalized Veterans By Income

Source: Seiling, Virginia, and Page, William Frank, *Health Characteristics of Veterans and Nonveterans: Health Interview Surveys, 1971-1974.* Veterans Administration, Controller Monograph No. 11, April 1980.

Chapter III

REQUIREMENTS FOR CARE: UTILIZATION AND PROJECTED NEEDS

Many aging veterans will never make use of the resources of the VA. Having lived full and economically successful lives, they will have provided for their own retirement and medical care through some combination of savings, investments, annuities, Medicare, and other forms of insurance. Many others will be primarily concerned with maintaining their health and will not suffer any protracted illness. While they will not be without chronic diseases, such illnesses often are not sufficiently debilitating to interfere with social, psychological or physical functioning. Where requirements for care do arise among elderly veterans, they are most likely to encompass a mix of both acute and chronic problems. The most important requirement in the care of the aging veteran is the same as for all of the aging population, that is, the elaboration of the existing model of care in order to incorporate a range and integration of services equal to the broader scope of their physical, psychological, social a economic needs.

While it is not possible to know precisely the extent of these needs without being able to project even simple parameters, such as insurance coverage, it is useful nevertheless to examine who among the total veteran population has in the past made use of the VA system. A decade ago the VA accounted for one of every twelve days of general hospital adult care given in the United States and one of every eight-and-one-half days of psychiatric hospital care. If these statistics are projected to the turn of the century, when two of every three males over 65 will be a veteran, the requirements for care could be immense, depending upon the veteran's choice of hospital. Implicit here are two assumptions: that the demand for care will increase with age, and that veterans will choose a VA facility for delivery of their care in the same proportion as in the recent past.

Page (1982) has explored the choice of VA hospitals and how age, income, health insurance, and service-connected disability of the veteran influence this choice. Table 3 shows the distributions of these four variables for a sample of 1260 veterans who were hospitalized according to their choice of a Veterans Administration hospital.[+] Overall one of every six in the sample of hospitalized veterans had used a VA hospital at least once. Those under 45 years of age were nearly twice as likely to use a non-VA hospital compared to those above 45. Those above 65 were not distinguishable from those 45 to 65. Veterans with health insurance used a non-VA hospital over four times more frequently than those without health insurance. While veterans with service-connected disabilities were three times as likely, veterans with non-service connected disabilities and low income were five times as likely to use VA facilities. Veterans with incomes under $10,000 were four times as likely to use VA hospitals as those with high incomes. Of the four variables explored by Page, age had the weakest effect on utilization of VA hospitals and is independent of the other three variables.

[+] The service-connected disability variable is of less interest when considering projections beyond age 65 since ability to pay without a service-connected disability is not then a factor.

Table 3

Percentage of Hospitalized Veterans With Hospital Episodes in VA Hospitals by Age, Income, Insurance and Service-Connected Disability*

Category	Percent with VA Hospital Episodes	Total Number of Hospitalized Veterans in Category
Total	16.5	1260
Age		
Under 45	11.2	373
45-64	18.6	678
65 and over	19.2	209
Income		
Under $10,000	29.3	527
Over $10,000	7.3	733
Insurance		
Yes	10.6	1036
No	43.6	224
Service-connected Disability		
Yes	38.4	211
No	12.1	1049

*Page, William Frank, Why Veterans Choose Veterans Administration Hospitalization: A Multivariate Model. Medical Care, March 1982, Vol. 20, No. 3.

Insurance was also independent of the other three factors, even though insurance and income are both highly related to the choice of VA hospitals. Considering the importance of these two variables makes feasible the assumption that any change in Medicare and Medicaid entitlements will directly affect future requirements for delivery of care through the VA system. If benefits are increased or coverage expanded, this might erode the need for Veterans Administration services, since veterans with insurance coverage are less likely to employ VA facilities. Conversely, if Medicare/Medicaid benefits were to be sharply curtailed while veterans' entitlements under P.L. 91-500 remain unchanged, the demand for VA services might show a dramatic increase. Evidence for the first scenario is derived from the experience of a decline in VA hospital usage rates immediately following the initiation of Medicare.

It is noteworthy that little experience is yet available on the utilization of services by the 75 and above age group or by the very old, that is, 85 and above. What evidence is available indicates marked increase in utilization of health services but whether this is differentially so for VA facilities is not yet apparent.

To understand what progress has been made and what the projected unmet needs will be, it is important to look first at utilization of inpatient and outpatient hospital resources. Following this will be a review and projection of the resources available to the VA for long-term care. Key indicators are admission rates, length of stay, and discharges. Because the older veteran stays longer, a disproportionately larger number of beds will be required to meet his needs in the acute care setting. In the immediate future,
"The typical VA hospital patient will not only be older, but will be a patient with more complex problems requiring additional care. He will require more staffing and more resources. Not only will 58 percent of hospital discharges be made by older veterans, but they will probably consume significantly more than 58 percent of available resources." (Seitz, 1981)

In 1981 the average daily census in VA hospitals was 65,450 for all patients. By the year 2000 this census is projected to be 98,000, an increase of 50%. When projected by age, however, the increase is estimated to be 280% for veterans 65 and over. The total need is exacerbated by slightly higher average short-term lengths of stay+ as age increases. Veteran patients under 65 average 15.1 days; 65 to 74, 15.8 days; and 75 or older, 16.9 days. When number of discharges are multiplied by average duration of stay, it is possible to estimate the total number of patient days generated in the system. Table 4 projects these calculations by each of the three age categories for 1979 discharge data and the projected discharges in the year 2000. While there is a dramatic decline in utilization projected for the group under 65, this is more than matched by dramatically increased needs for the over 65 age groups. When aggregated, the overall generated patient days are expected to rise from 14,133,945 to 19,018,282 for an increase of 35% in utilization of inpatient resources.

Other estimates based upon overall length of stay would be higher, biased by unusually long lengths of stay found in VA hospitals but not in private hospitals. When based only on discharge data, the projected increase from 1980 to 2000 is estimated to be 29% (Table 5).

+ Computation of short term length of stay excludes lengths of stay over 100 days.

Table 4

NUMBER OF HOSPITAL PATIENT DAYS GENERATED BY AGE CATEGORY

FOR 1979 AND 2000[1]

AGE	1979 DISCHARGES	AVERAGE* SHORT TERM LENGTH OF STAY	GENERATED PATIENT DAYS	PROJECTED 2000 DISCHARGES	AVERAGE* SHORT TERM LENGTH OF STAY	GENERATED PATIENT DAYS	NET DIFFERENCE BETWEEN 1979 AND 2000
LESS THAN 65	710,576	15.1	10,729,697	500,136	15.1	7,552,053	-3,177,644
65 - 74	128,152	15.8	2,024,802	344,267	15.8	5,439,419	+3,414,617
75 OR OLDER	81,624	16.9	1,379,446	356,616	16.9	6,026,810	+4,884,337
OVERALL	920,352	—	14,133,945	1,201,019	—	19,018,282	+4,884,337

*NOTE: Excludes Lengths of Stay over 100 days.

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[1] Seitz, Larry A., The Aged Veteran: Part 1. The Impact Upon the VA Health Care Delivery System of Older Veterans: The Hospital Inpatient System. Health Systems Information Service, Office of Planning and Program Development, VA Department of Medicine and Surgery. HSIS Report 81-8, October, 1981, p. A-6.

TABLE 5

PROJECTED (AGE ADJUSTED) DISCHARGES BY MEDICAL SPECIALTY FOR THE YEAR 2000*

MEDICAL SPECIALTY	FY 1980 DISCHARGES	PROJECTED 2000 DISCHARGES	DIFFERENCE	PERCENT CHANGE
General	358,064	519,409	+161,345	+ 45%
Cardiology	24,044	33,429	+ 9,385	+ 39%
Pulmonary	18,653	27,411	+ 8,758	+ 47%
Gerontology	8,736	19,320	+ 10,584	+121%
Gastroenterology	9,125	10,740	+ 1,615	+ 18%
Hematology	6,159	9,392	+ 3,233	+ 52%
Neurology	27,989	34,837	+ 6,848	+ 24%
Rehabilitative Medicine	4,805	6,138	+ 1,333	+ 28%
General Surgery	159,903	210,309	+ 50,406	+ 32%
Neurosurgery	11,282	11,234	- 48	- 1%
Ophthalmology	16,920	29,435	+ 12,515	+ 74%
Orthopedic	36,256	39,319	+ 3,063	+ 8%
Otorhinolaryngology	17,577	19,378	+ 1,801	+ 10%
Plastic Surgery	7,574	9,164	+ 1,590	+ 21%
Thoracic Surgery	7,927	8.895	+ 968	+ 12%
Urology	42,284	71,641	+ 29,357	+ 69%
Psychiatry	166,724	130,672	- 36,052	- 22%
Other	9,614	10,296	+ 682	+ 7%
OVERALL	933,636	1,201,019	+267,383	+ 29%

SOURCE: Twenty Percent Sample of the FY 1980 Patient Treatment File

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* Seitz, Larry A., The Aged Veteran: Part 1. The Impact Upon the VA Health Care Delivery System of Older Veterans: The Hospital Inpatient System. Health Systems Information Service, Office of Planning and Program Development, VA Department of Medicine and Surgery. HSIS Report 81-8, October, 1981, p. A-9.

Of further interest in Table 5 are the projected differences for the various specialties. Expected is the more than doubling of projected discharges from gerontology. Psychiatry shows a decline of 22% but deserves a cautionary note. Because this is an aggregated total, the higher frequency of psychiatric illness in the younger age range and its decline with age masks the actual needs in the very elderly group. In current VA hospital admissions, diseases of the vascular, pulmonary, and urinary tract systems, along with malignant neoplasms, dominate in patients 65 or older; (Seitz).

Similar age related findings were obtained for outpatient visits. Table 6 indicates a three-fold increase from 1979 to 2000 for patients 75 and over, a near doubling of those 65 to 74, and a 30% decline in the number of visits by veterans less than age 65. When these increases and decreases are aggregated, a modest increase of some 13% can be expected over the next 20 years in outpatient visits.

Table 6

NUMBER OF STAFF OUTPATIENT VISITS BY AGE CATEGORY
FOR 1979 AND 2000

AGE	1979	2000 WITH 2000 AGE DISTRIBUTION	NET DIFFERENCE BETWEEN 1979 AND 2000	PERCENT CHANGE
LESS THAN 65	12,408,000	8,656,000	3,752,000	- 30%
65-74	1,890,000	5,061,000	3,171,000	+168%
75 OR OLDER	755,000	3,285,000	2,530,000	+335%
OVERALL	15,053,000	17,992,000	1,949,000	+ 13%

Source: Adapted from Seitz, Larry A. VACO briefing.

By the year 2000, the common age related chronic diseases including hearing and visual impairments, dementing illnesses especially Alzheimer's disease, the aftermath of stroke, Parkinsonism, arthritis and bone diseases, and periodontal diseases will become dominant health problems stressing the capacity of VA health resources to provide comprehensive patient care.

Clearly some of the increased needs of aging veterans will be offset by a decline in the number of younger veterans. Nevertheless, based on estimates of patient days, Seitz projects by the year 2000 an additional expenditure of 752 million dollars over and beyond FY 1980 costs.

Data on options for long-term care are less well developed. Estimates of patient activity are available through 1988 for six types of care:

VA Nursing Home Care
Community Nursing Home Care
State Home Nursing Home Care
State Home Hospital Care
VA Domiciliary Care
State Home Domiciliary Care

These six types of extended care facilities project an estimated census increase of 16.8% by 1988. This will derive primarily from VA facilities' expansion and increased utilization of community nursing homes. Increases here are offset by decline in utilization of State Home hospitals and domiciliaries. Table 7 offers a synopsis of estimated growth in these facilities over the next five years. In addition, care is given to patients in intermediate care beds. Though these are actively being utilized for long term care these are folded in with data on acute care.

Table 7

PERCENTAGE INCREASE IN NUMBER OF FACILITIES AND PATIENT CENSUS 1983-1988 FOR SIX TYPES OF LONG TERM CARE

Number of facilities	1983 Estimate	1988 Estimate	Percent Increase
VA Nursing Home	101	124	22.8
Community Nursing Home	3,200	3,200	0.0
State Home Nursing Home	41	46	12.2
State Home Hospital Care	7	7	0.0
VA Domiciliary Care	16	16	0.0
State Home Domiciliary Care	43	45	4.7
Census			
VA Nursing Home	8,974	11,881	32.4
Community Nursing Home	10,000	13,216	32.2
State Home Nursing Home	6,744	7,749	14.9
State Home Hospital Care	590	590	0.0
VA Domiciliary Care	7,000	5,500	(21.4)
State Home Domiciliary Care	4,856	5,658	16.5
TOTAL CENSUS	38,164	44,594	16.8

SOURCE: Office of Geriatrics and Extended Care, Department of Medicine and Surgery, Veterans Administration, 1982

Other efforts to forecast the VA nursing home census from population projections show an accelerated growth in the estimated nursing home utilization by all veterans through the year 2000. Estimates of the VA's market share of nursing home utilization varies tremendously depending on what assumptions one makes. At one end of the spectrum of estimates for the year 2000 is the low census figure 52,197 based on VA support of 16% of the nursing home market for all veterans. An alternative assumption that the VA will support 100% of the market for all veterans, given the higher estimate, would yield a census of 545,259, more than ten times higher than the lowest estimate. Such a range of estimates is not particularly useful for planning but is useful as an illustration of how varied the actual demand on VA resources might be. The conservative midpoint estimate based on the assumption of 16% of the market suggests a need for some 70,000 VA supported nursing home beds by the year 2000. Even with this conservative estimate the available resources will need to be more than doubled between now and then. Table 8 summarizes the projected nursing home needs to the year 2000.

The utilization projections presented are based on the assumption (in addition to assumptions previously noted) that current health care practices which determine long term care will continue essentially unchanged. Actually, changes are already being undertaken which will almost certainly affect the extent and types of utilization of long term care. In particular, the increasing development of geriatric evaluation units in the VA gives promise for assisting frail older patients to obtain care appropriate to their needs, with emphasis on maintaining veterans at home.

There is evidence in the VA to suggest that a geriatric evaluation unit can achieve more optimal placement of some patients and other patients may be returned home rather than being institutionalized. Based on such findings one Medical Center has adopted the requirement that all veterans being considered for long term institutional care will be admitted and transferred to a geriatric evaluation unit as the key step in decision-making, prior to any admission to long term care services. It may be expected that continued growth in such geriatric inpatient (and outpatient) assessment services will modify the future utilization patterns significantly.

Relations Between Acute Care and Chronic Care

In a recent review of long-term care planning by Health Systems Agencies, Brody and Woodfin (1979) found

> "...that few HSA's are actively engaged in planning for long-term care as a system: all are primarily concerned with the establishment of the ratio of skilled nursing facility (SNF) and intermediate care facility (ICF) beds per 1,000 population; and, many have a similar interest in creating some population ratio for the provision of home health care. Thus, the efforts for data collection are concentrated on justifying the SNF/ICF bed ratios, an approach rooted in the resource allocation procedures of the Hill-Burton program based on the Hospital Survey and Construction Act of 1946."

Table 8

VA Supported Nursing Home Utilization

Five Alternative Sets of Census Projections

Scope: National, Projected to 1985, 1990 and 2000

Alternative Policies For VA's Market Share	1985			1990			2000		
	Low Est	High Est	Mid-Pt	Low Est	High Est	Mid-Pt	Low Est	High Est	Mid-Pt
1. VA Will Support 16% of the Nursing Home Market for All Veterans	32,345	43,784	38,165	36,672	56,528	46,600	52,197	87,241	69,719
2. VA Will Support 20% of the Nursing Home Market for All Veterans	40,682	54,730	47,706	45,840	70,660	58,250	65,246	109,052	87,149
3. VA Will Support 35% of the Nursing Home Market for All Veterans	71,193	95,777	83,485	80,220	123,656	101,937	114,180	190,840	152,810
4. VA Will Support 50% of the Nursing Home Market for All Veterans	101,704	136,825	119,265	114,600	176,649	145,624	163,115	272,629	217,872
5. VA Will Support 100% of the Nursing Home Market for All Veterans	203,409	273,650	238,530	229,199	353,298	291,249	326,230	545,259	435,745

Hospital discharge rates continue to be employed as one method of accounting for utilization of system resources (See Figure 7). As the VA moves to involve community and famiily resources along with its hospitals and expanded nursing home facilities it will begin to fill in the gaps that still exist in any rational plan of care for the aging veteran. In this, the dominance of the large number of acute care beds must be continually re-examined. It is here, for example, that the need for health services research can be clearly seen. An example is presented in the diagram shown in Figure 8. In this chart, admission to and from nine different sources are mapped to give some sense of the dynamic quality of the flow of patients through the system. Still dominant is the VA hospital with the vast majority of patients being processed through this mechanism. It should be noted, however, that these hospital statistics include the data on intermediate care units. Seven of every ten admissions (4,010) to VA nursing homes come from a VA hospital, most of the others (1,763) being admitted directly (1,566). In turn, the 5,773 admissions to the VA nursing homes were the source of 5,119 separate admissions to VA hospitals, though they may have returned to the nursing home.

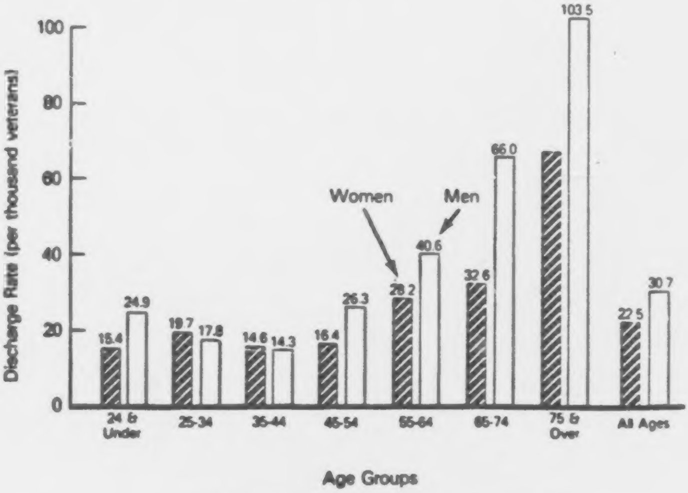

Figure 7. VA Hospital Discharge Rate (per thousand) for Men and Women Veterans By Age Group (FY 79)

Source: *Women Veterans Usage of VA Hospitalization*, Office of Reports and Statistics, Research Division, Veterans Administration, August 1981.

In a number of significant ways, however, the VA has gone beyond the limited criterion of bed utilization and in so doing has endeavored to better define the relationships between acute and chronic care. The schema presented by Brody and Mascioechi in Figure 9 represents a sound conceptual elaboration that more completely describes an array of services along a continuum from "least restrictive" to "most restrictive" services. The model offers a reference against which the development of the VA's long-term care system might be evaluated.

The care of the older veteran patient will necessarily require a mix of providers given the propensity of the elderly for multiple illnesses and failing social support systems. The patient is often required to visit a variety of specialists, nursing staff, therapists, and social workers during any given treatment visit. Over his lifetime the patient may experience episodes of acute and chronic, institutional and non-institutional care provided by different health professionals in different configurations. The fragmentation that exists along this continuum of care is not a function of the number of providers but a failure to coordinate the appropriate services.

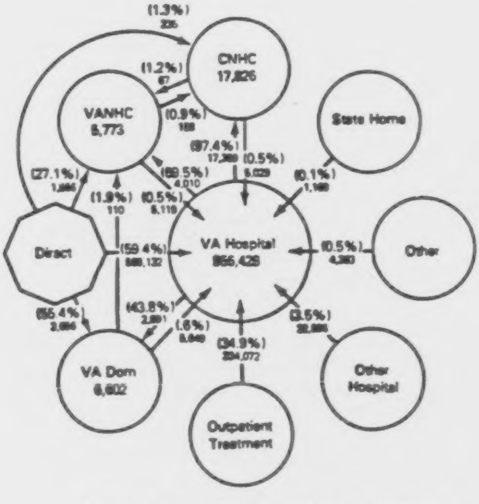
(1.3%)
226
CNHC
17,826
(1.2%)
67
VANHC
5,773
(0.9%)
168
State Home
(97.4%)
17,380
(0.5%)
5,029
(89.5%)
4,010
(0.1%)
1,168
(27.1%)
1,886
(1.9%)
110
(0.5%)
5,110
Direct
(59.4%)
508,132
VA Hospital
856,428
(0.5%)
4,380
Other
(56.4%)
3,886
(43.8%)
2,891
(.6%)
5,840
(34.9%)
304,072
(3.5%)
32,886
VA Dom
6,602
Other
Hospital
Outpatient
Treatment

Figure 8. Source of Admission FY 82 for VA Hospital, Nursing Home and Domicilliary Care

Source: Office of Geriatrics and Extended Care, Division of Medicine and Surgery, Veterans Administration, 1983

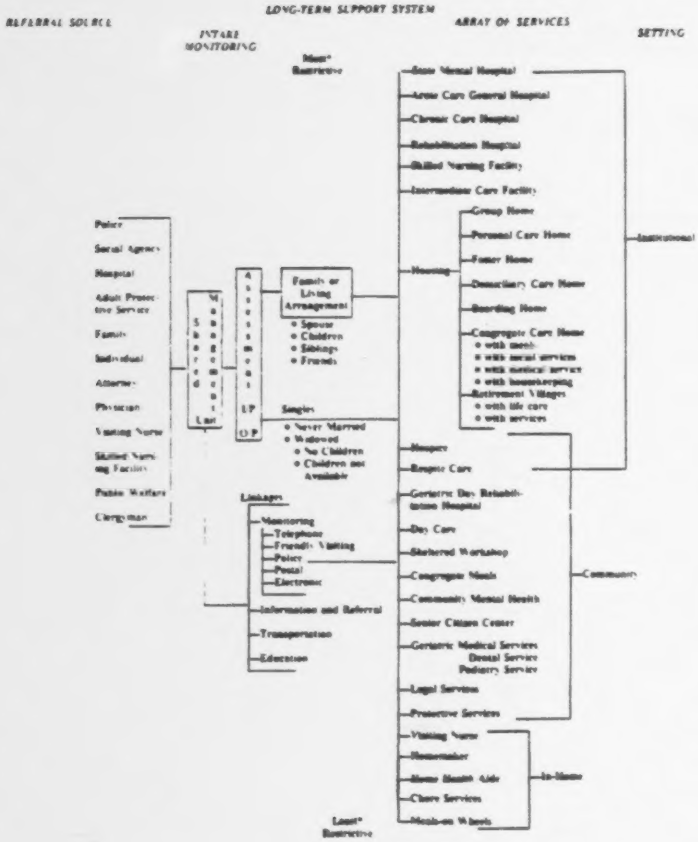
LONG-TERM SUPPORT SYSTEM
REFERRAL SOURCE
INTAKE MONITORING
ARRAY OF SERVICES
SETTING
Most* Restrictive
Police
Social Agency
Hospital
Adult Protective Service
Family
Individual
Attorney
Physician
Visiting Nurse
Skilled Nursing Facility
Public Welfare
Clergyman
Shared Management Unit
Assessment
I.P
O.P
Family or Living Arrangement
• Spouse
• Children
• Siblings
• Friends
Singles
• Never Married
• Widowed
• No Children
• Children not Available
Linkages
Monitoring
Telephone
Friendly Visiting
Police
Postal
Electronic
Information and Referral
Transportation
Education
State Mental Hospital
Acute Care General Hospital
Chronic Care Hospital
Rehabilitation Hospital
Skilled Nursing Facility
Intermediate Care Facility
Housing
Group Home
Personal Care Home
Foster Home
Domiciliary Care Home
Boarding Home
Congregate Care Home
• with meals
• with social services
• with medical service
• with housekeeping
Retirement Villages
• with life care
• with services
Hospice
Respite Care
Geriatric Day Rehabilitation Hospital
Day Care
Sheltered Workshop
Congregate Meals
Community Mental Health
Senior Citizen Center
Geriatric Medical Services
Dental Service
Podiatry Service
Legal Services
Protective Services
Visiting Nurse
Homemaker
Home Health Aide
Chore Services
Meals-on Wheels
Institutional
Community
In-Home
Least* Restrictive

Figure 9. Inventory of Recommended Available Services, Appropriate to a Long-Term Care Support System*

* The classification of from most to least restrictive is a general view of services and may vary within each service.

Source: Brody, S.J. and Masciocchi, C. "Data for Long-Term Care Planning by Health Systems Agencies", AJPH, 1980, 70(11), 1194-1196.

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DESCRIPTION OF THE VETERANS ADMINISTRATION EXTENDED CARE PROGRAMS

In addition to the 172 acute care hospitals located throughout the United States, the VA has embarked upon program expansion in a number of areas intended to be responsive to the overall needs of the aging veteran. A large proportion of intermediate care beds are occupied by older patients with chronic debilitating problems requiring skilled nursing care. In some cases there appears to be an overlap with the nursing home program. The Committee appreciates the need to provide such services and is aware of the VA's efforts to more clearly define the role of intermediate care in meeting the needs of older veterans. In addition to intermediate care there is a full spectrum of institutional and non-institutional care in the VA. The programs are characterized as follows:

Institutional Extended Care Programs

VA Nursing Home Care. The nursing home care units located in VAMCs provide skilled nursing care and related medical services, as well as opportunities for social, diversional, recreational, and spiritual activities. Nursing home patients typically require a prolonged period of nursing supervision and rehabilitation services to attain and maintain optimal function. In FY 1982, 15,072 veterans were treated in VA nursing homes which had an average daily census of 8,486 patients. At the end of 1982 there were 97 VA nursing homes having a total of 9,239 beds.

Community Nursing Home Care. This is a contract program for veterans who require skilled or intermediate nursing care to assist them in making the transition from a hospital to the community. In FY 1982, 31,658 veterans were treated in approximately 3,200 community nursing homes in the 50 states and Puerto Rico. These facilities had an average daily census of 9,525. Toward the latter part of FY 82, average daily census increased to over 10,000.

VA Domiciliary Care. Domiciliary care in VA facilities provides necessary medical and other professional care for eligible ambulatory veterans who are disabled by age, disease, or injury and are in need of care but do not require hospitalization or skilled services of a nursing home. In FY 1982, 14,535 veterans were treated in 16 VA domiciliaries which had an average daily census of 7,087. The end of 1982 saw 16 domiciliaries with 8,230 beds in the VA system. The average attained length of stay of domiciliary patients is 1,471 days.

State Veterans' Homes. The VA relationship to State Veterans' Homes is based on two grant programs: Per diem and construction. The per diem program enables the VA to help fund the States in providing direct hospital, nursing home and domiciliary care to veterans eligible for VA care. The other grant program provides VA assistance in funding for construction of new State domiciliary and nursing home care facilities and the expansion, remodeling or alteration of existing facilities.

Non-Institutional Care Progams

Hospital Based Home Care. This program provides chronically ill veterans with services in their own homes. A treatment team provides medical, nursing, social, dietetic, and rehabilitation regimens, and trains family members in ongoing care of the patient. In FY 1982, 144,100 home visits were made by health professionals, and 6,524 patients were treated.

Adult (Geriatric) Day Health Care. This demonstration program provides health maintenance and therapeutic activities in a congregate setting for veterans who would otherwise require continued and full-time institutionalization. Advances in the understanding and treatment of certain illnesses of the elderly now make it possible for many of these persons to function independently with the partial care offered by these centers. There are a few demonstration projects currently in the system.

In addition, a program concerned with being a "catalyst" in geriatrics at a VA medical center exists:

Geriatric Research, Education, and Clinical Centers (GRECCs). The GRECC Program consists of eight centers and represents an important aspect of the response to the health care needs of aging veterans. It serves to attract and develop superior staff in the field of gerontology and geriatrics, and to advance and integrate research and educational achievements into the VA health care system. The GRECC Program is covered in more detail in Appendix B of this report.

In the years that have elapsed since submission of the Aging Veteran report, the VA DM&S has undertaken to establish and elaborate a range of alternatives for extended care. These represent sound beginnings. Whether or not the rate of development will keep pace with projected needs remains an issue of concern.

Chapter IV

THE ROLE OF THE VETERANS ADMINISTRATION HEALTH CARE SYSTEM IN THE EDUCATION OF HEALTH PROFESSIONALS

If quality of health care is to be maintained for an aging population, the educational system that supplies the health professionals must itself change. Herein lies perhaps the greatest opportunity and the greatest challenge for the VA as it addresses the future care of the aging veteran. Without health professionals well trained in the nuances and complexities of geriatric care, the VA system risks a decline in the quality of care equivalent to the impressive gains made over the past thirty years. Key to all of this is the role of the VA health care system in the education of health professionals:

It is highly likely that the World War II veteran who elects to receive his health care in a Veterans Administration facility over the next ten to twenty years will contribute to the learning experience of a large segment of the next generation of health professionals.

Because this next generation of health professionals will spend the majority of their professional lives caring for a patient population dominated by elderly citizens across the entire spectrum of the society, it is critical that the educational role played by the VA be carefully weighed in planning for the future. This role is at once part of the problem, the potential solution, and may well be the last main policy leverage available at a national level to effect change in how we prepare our health providers to care for a graying America. In this regard there is value in briefly noting the history of VA involvement in the education of physicians.

The DM&S was established under Public Law 79-293 in 1946. It called for expansion and upgrading of existing VAMCs to provide for the medical needs of returning World War II veterans. The law also provided for the development of working agreements between VAMCs and United States medical schools. The legislation encompassed research and the education of other health professionals as well.

Intriguing is the role that Dr. Paul Magnuson played in assuring high quality care for American veterans upon their return. In his autobiography, "Ring the Night Bell," (1960) Magnuson describes the veterans hospitals at the close of World War II.

> "There was not a single veterans hospital that was accredited by the American Medical Association for residencies or internships. They were not even called hospitals—the official name for them was 'Veterans Administration facilities.' The doctors in those places were the most dispirited, downtrodden bunch you ever saw."

Upon assuming the position of Director of Research and Education in the Medical Division under Generals Bradley and Hawley, Magnuson set out his ideas for assuring quality care for the returning veteran in his now famous five page memorandum, the essence of which was:

> "...that when the Veterans Administration built or leased or otherwise created new hospitals to meet the tremendous need that was coming, it ought to put them near established medical schools and make them teaching hospitals... I suggested that the Veterans Administration arrange to have the deans of the medical schools staff the hospitals, putting in chiefs of service, residents and interns. In this way the Veterans Administration would be drawing on the cream of the civilian medical profession." (p. 269)

Following his service to the VA, Magnuson served as the chairman of the President's Commission on the Health Needs of the Nation. He undertook to establish a first-class rehabilitation center in Chicago. His comments on this activity were as prescient as was his five page memorandum.

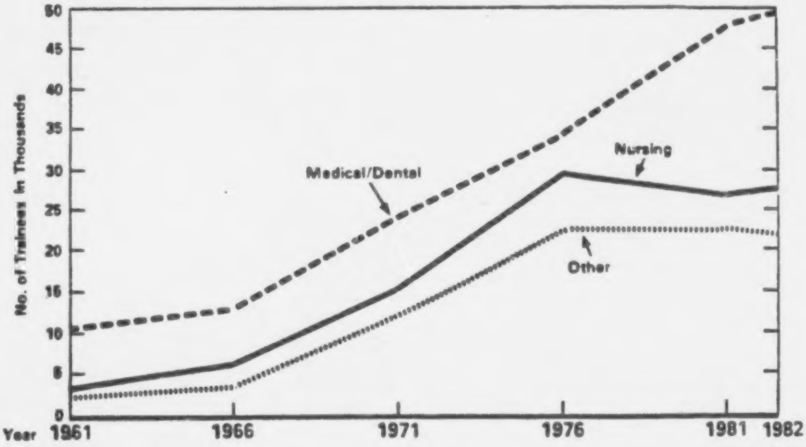
> "For a long time, in fact most of my professional life, I had thought we were not doing nearly as much as we could for people who had been disabled by illness or injury. If a man pulled through a heart attack, or his life was saved by cutting off his leg, his doctor considered him 'cured'; but in the eyes of the community, he was a cripple or an invalid, unemployed and unemployable... He was a burden on his family and the community." (p. 366)

> "Rehabilitation calls for a tremendous team effort. It ought to begin with the doctor at the moment when the patient first comes to him. He should plan his entire treatment with the patient's restoration to normal life in mind, and never let him start down the road to despondency. Then, during the convalescence and afterwards, we need a physical therapist to minimize the crippling, and build up other muscles or other blood vessels or nerve channels to do the work of those that are out of action. We need clinical psychologists to cope with the patient's morale problems and find out what sort of work he is mentally and physically adapted to. We need an occupational therapist to train him for a job, and then somebody to help him find and get the job. During this whole process we must constantly keep ourselves informed, through a variety of tests, as to just how much the patient really can undertake in safety." (p. 367)

One can only wonder how Dr. Magnuson's five page memorandum would be written today were he given the task of planning for the aging veteran.

Set up as a way to ensure oversight of the quality of care, and as an inducement in the recruitment of physicians with sound professional credentials, Manguson's pattern of medical school affiliation served the American veteran well. In the ensuing years a majority of the VA hospitals have been thoroughly integrated in ever-developing modern academic medical centers with the medical schools as their major component. The range and extent of training supported by the VA on a national level is second to no other educational or health care organization. Nearly 100,000 health professionals annually receive all or part of their training in a VA facility. The growth of this activity, which has doubled even within the last decade, is documented in Figure 10. One-fourth of these 100,000 are medical house staff, one-fifth medical and dental students, and one-fourth nursing professionals. Of some 25,000 house staff training in VA hospitals, 7,700, or one out of six of all residents in training, are supported by the VA and contribute significantly to the service delivery mission of the agency.

As the VA role in health professions education became established, other changes in the character and mission of a contemporary medical school were taking place. Expanded and developed by a steady flow of federal research dollars, the contemporary American medical school became part research institute, as well as educational organization, and the VA hospitals also became full partners in the massive development of clinical research. This research growth has led to higher order technology in the delivery of health care and to a level and quality of care unsurpassed in the history of medicine. It was accompanied, too, by a move to specilization and subspecialization and by a focus on acute medicine and hospital based secondary and tertiary care. Through all of this, the American veteran received his promised entitlements in a hospital setting overseen by physician professors, many of whom were themselves in the vanguard of research on dread diseases. Throughout this time, the veteran also grew older, his life expectancy enhanced by the quality of care delivered in the secondary and tertiary care hospitals developed through the bond between the VA and medical education. Whereas the average World War I veteran may have died some few years "prematurely," his World War II counterpart could expect to live nearly two decades longer.



Year	1961	1966	1971	1976	1981	1982
Med./Dental	10,976	13,219	24,738	34,700	47,329	49,020
Nursing	3,210	6,394	15,917	29,820	26,853	27,622
Other	2,343	3,773	12,431	22,578	22,676	21,861
TOTAL	16,529	23,386	53,086	87,098	96,858	98,503

Figure 10. Growth in Numbers of Trainees in Department of Medicine and Surgery By Major Category

Source: Office of Academic Affairs, Department of Medicine and Surgery, Veterans Administration. RCS 15-10, January 1983.

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The natural processes of aging and chronic illness have superceded the onslaught of acute disease just at the time when a large number of veterans, the World War II cohort, are entering the upper age range. And the system that fostered this longevity is no longer fully appropriate to the needs of this constituency. Secondary and tertiary treatment facilities geared to respond to acute illness can no longer completely meet the needs of the World War II veteran as appropriately as they once did. The intellectual and professional contributions that followed from the affiliation bond to medical education contributed much to the VA hospital system but with the changing demographics that bond should now be reexamined. If the dilemma of chronic and long term care of the aging veteran by a short term acute care system is to be solved, the basic bond should be reestablished on revised and reordered bases.

To fulfill the health care needs of the aging veteran, and of a "greying America," a number of issues must be addressed. The frail elderly are often at higher risk for iatrogenic illness in an acute care setting. The acute care setting is costly for short term illness, doubly costly as a medium for long term care. Cost factors in turn drive consideration of alternative models involving self care and home care, utilization of existing and alternative community resources, and concern for a redefinition of what quality care is for those elderly patient who might suffer more from family separation than from physical debilities.

Generation of alternative models of care accompanied by selective development of physical facilities and exemplary sites for the training of health manpower represents at once an opportunity to repay the medical education and research establishment for the legacy of three decades of quality acute care for American veterans, while at the same time ensuring for the future continued maintenance of the same high quality care in a mode appropriate to the changing needs of the aging veteran population. The seeds of responsiveness to those educational requirements geared to geriatric needs are found in a number of activities initiated by DM&S (Dube and Mather, 1981). These efforts include:

The Geriatric Fellowship Programs for Physicians and Dentists
The Interdisciplinary Team Training in Geriatrics Program
The Nursing Scholarship Program (Geriatrics)
A compendium of behavioral objectives for geriatric education
A variety of education and training programs in geriatric medicine and gerontology delivered through the GRECCs
Continuing education programs in geriatric medicine and gerontology sponsored both by the Regional Medical Education Centers (RMECs) and by the National Continuing Education Project
Workshops in geriatric dentistry resulting in an anthology concerning aspects of the aging process
Programs for Clinical Nurse Specialists and for Gerontologic Nursing Care
The Manpower Grants Program to medical schools and other academic institutions for training in geriatrics

Particularly noteworthy has been the development of the Geriatric Fellowship Program. By 1982, the VA had undertaken to prepare physicians and dentists for clinical excellence in geriatric medicine and gerontology, for leadership, management and administrative abilities, and for becoming role models for graduate and undergraduate students.

Candidates for the two physician fellowship positions open per year at each of 12 sites must be certified or at least eligible for certification by an American specialty board in internal medicine, family practice, neurology, or psychiatry. All internal medicine subspecialties are also eligible, since internal medicine is the foundation of this initiative in geriatric medicine.
Five of the twelve program sites are located at VAMCs hosting GRECCs. Of the five dental fellowship program sites two are located at VAMCs hosting GRECCs.

Fellows prepare annual curriculum plans identifying individual learning goals and outlining objectives and methods for accomplishing these goals under the guidance of the program director. They are involved in patient care, teaching of medical students and house staff, attending and presenting seminars, and conducting research. Fellows also coordinate interdisciplinary teams and interact in the community with institutions for care of the elderly. Depending on the availability of funds, an option for a third year of support is available, on a competitive basis, for the purpose of research training in geriatrics.

The five year history of the program is reflected in Table 9. To date 56 physicians fellows have completed the 2 year program. Of these 40 or 71% have found employment in the VA. Projections for the candidates now in the program indicate that this experience can be maintained as the program's reputation grows within the system and the graduates are increasingly sought after by the VAMCs.

Table 9

History of Participation in

The Physician Geriatric Fellowship Program+

Academic Year	No. 1st-Yr Fellows	No. Completing 2 Yrs Trng	Percent VA Employ	Third Yr Research
1978-79	9	N/A	N/A	N/A
1979-80	16	8	50	N/A
1980-81	19	13	77	2
1981-82	19	16	69	2
1982-83++	[illegible]	19*	75*	-

+As of March, 1983

* Anticipated

++ In 1982 [illegible] first 5 dental fellows were selected

The program is also coming to fruition inasmuch as the geriatric fellows who have exhibited high level skills and are now in VA/academic positions represent strong possibilities for expansion of the total number of sites. In addition, those sites that have soundly functioning geriatric evaluation units can be invited to expand the number of fellows they are presently training. Thus, for the next two years a doubling of the number of physician fellows per site and the doubling of the number of sites would allow for the expansion of the program from 24 fellows per year to 96 fellows per year. If by the third year the total number of sites could be tripled with 6 fellows per site selected each year the production of fellows could then be increased to over 200 per year thereby ensuring a minimum supply of physicians well trained in geriatric medicine. The development of the role of the Geriatric Evaluation Unit at each of the 172 VAMCs could alone accommodate the output of such an expansion over a period of five to seven years.

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CHAPTER V

THE ROLE OF RESEARCH IN THE DEPARTMENT OF MEDICINE AND SURGERY

Overview of Research and Development Activities

The VA DM&S research and development program is organized and administered as three components: 1) medical research; 2) health services research and development and; 3) rehabilitation research and development.

The medical research service provides opportunities for basic science and clinical investigation. For FY 1982, there were 5,407 principal and secondary investigators throughout the system including physicians, dentists, nurses, clinical psychologists, pathologists, biochemists and a variety of other clinical and basic scientists. Their various projects, including an estimated 400 that were related to aging, were funded both centrally and at the facility level, and by a variety of federal and non-federal sources. There were 1,494 programs (some via cost center 103). An additional 93 merit reviewed programs were supported by high priority cost center 106 funds, 40 of which were in the field of gerontology and geriatrics (cost center 106G).

In addition to the special problems of the veterans (stress disorders or Vietnam Era Veterans, Spinal Cord and Regeneration, Possible Adverse Effects of Exposure to Herbicide, Injuries Related to War-time Experience), studies of a variety of health problems of veterans (including cancer, diabetes, chronic heart disease and chronic pulmonary disease) receive support from the research and development budget.

Some VA medical research studies (24 in FY 1982) of important health problems are conducted cooperatively at two or more VAMCs. Examples of cooperative studies include the evaluation of pneumococcal vaccines in patients at high risk to develop pneumococcal disease: the elderly, patients with diabetes mellitus, patients with chronic alcoholism, and patients with chronic renal, hepatic, cardiac or pulmonary disease. Continuing cooperative studies involving seven VAMCs assess different anti-hypertensive regimens with regard to their effects on daily living, and the emotional and intellectual functioning of the elderly veteran.

All of the various studies discussed above receive support from the Medical Research Service. In FY82 that service received approximately 90% of the approximately $140,000,000 funding for research in the VA DM&S. As a percent of the total budget for medical care, the Research and Development budget was 1.92% in FY 1982, down from 4.0% in 1970 and 2.20% in 1979. It is estimated to be 1.95% in FY 1983. In FY 1982 aging was identified as either the primary, or secondary program research area by 292 principal investigators, who were awarded a total of $9,225,333 for their research projects.

There is a special aspect to the medical research program to provide "seed money" to new investigators in the VA. Every two months, applications by new investigators are reviewed by regional Research Advisory Group (RAG) merit review committees. A RAG budget generally does not exceed $25,000 annually. If approved, these are promptly funded. The objective is to permit the new investigators to quickly begin a program of research, with the idea that they would be developing a regular 103 or 106 application for research support.

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Approximately 8% of the research budget goes to Rehabilitation Research and Development which is dedicated to improving the quality of life and functional independence of physically disabled and infirm veterans. Studies dealing with injuries are given top priority. Developments sponsored by this service include an improved wheelchair which uses ultrasound to avoid obstacles, computer terminals for low vision useful to blind veterans and word attachments for OPTICON reading machines for the blind. In addition, a major effort is in developing computer assisted manipulative devices for quadraplegic or other severely disabled veterans.

The three foci of the rehabilitation research program - prosthetic devices, spinal cord injury and sensory aids - are regarded by the Geriatric and Gerontology Advisory Committee as very important. Based upon the projected changes in the population demography, however, it is anticipated that the problems of sensory disabilities will become increasingly important.

The third, and smallest division, the Health Services Research and Development Service, is allocated approximately 2% of the research budget of the VA DM&S. Emphasis is on the generation and dissemination of information which is relevant to decision making by VA system managers, providers and consumers.

The mechanism for the granting of funds for research is the same in the medical and rehabilitation research programs, but the mechanism is somewhat different in the health services research program. In the former two programs, the flow is as follows: First, the individual investigator makes application for research funds and submits this application to the research and development committee of the local VA facility. This is done for initial evaluation as to general appropriateness and for categorization, as for example, 106 funding. The application is also submitted to either the human or to the animal subjects committee for ethics considerations.

Twice each year, applications are sent to VA Central Office for merit review. There are 14 merit review boards serving the medical research program. Each board consists of 7 to 15 members. There are additional merit review committees for the rehabilitation research division. Approximately one-third of the membership within a committee is composed of VA scientists and two-thirds of non-VA scientists. These members are selected on the bases of expertise in a particular area and a record of successful competitive research funding. Recommendations for merit review board membership are made by previous members, program specialists and through review of library searches. Initial screening is carried out by the merit review board staff and the Director of Medical Research Service. The final appointments are made by the Assistant Chief Medical Director for Research and Development.

The Medical Research merit review boards evaluate applications and give them priority scores from 10, (the highest quality) to 50 (the lowest quality): Until 1982, priority scores from 10 to 15 received 100% of recommended funding and scores from 35 to 50, up to 60% of funding. Currently, only applications with scores up to 35 are funded. There is 100% funding for scores up to 15, and increasingly diminished funding, down to grants with scores of 35, that received 70% of the approved budget. During 1982, 63% of applications were funded, 10% were approved but not funded, and the remainder disapproved. The average funding per proposal in FY 1982 was about $43,000.

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There is a special inducement for investigators in VA facilities that have GRECCs to carry out aging research. Each GRECC has its own theme, that is, each is charged to develop a general focus of excellence. Any investigator at the facility (whether or not the investigator is a member of the GRECC) who submits a research application in aging within the GRECC theme, has the designation 106G applied to the research proposal. The designation 103 is applied to all other merit reviewed research grant applications. Career investigations are funded by a separate cost center, 108. All approved 106G applications receive full funding regardless of priority score. There are other 106 programs within the VA and each of these are for research in areas deemed to be designated of special importance. Aging is one of these.

The Health Services Research Program has a different review and funding mechanism. Unlike the other programs, the review committees here are made up of ad hoc members. Further, the initial step of the funding process begins with communication with the Director of the Health Services Research and Development Service. The Director reviews the proposal and either discourages further application efforts, or encourages. The latter may take the form of aiding the applicant to develop a strong application. Once the application is approved it is totally funded as opposed to receiving a percentage of its budget as in Medical Research Service.

In addition, there are six field programs in health services research in the VA, each having a special health services research focus. The program located in the pacific nothwest has aging as its focus. This program is still in a developmental stage. The Committee believes health services research is very important, but the VA program does not seem to be completely developed. The six field programs do not meet the recommended goals for health services research as recommended by this Committee.

An important criterion for funding a health services research program is the relevance of the proposed research for immediate application to meet clinical needs. The outcomes of the research are to be made accessible to practitioners. All completed research investigations are reviewed to determine whether they had been carried out properly and whether the conclusions are compatible with the results.

The quality and results of VA sponsored research have been periodically documented. The Special Medical Advisory Group to the VA concluded in their report that the research budget, as a proportion of the total allocation to the DM&S is quite small. The research budget has not changed in real dollars since 1977. The Special Medical Advisory Group also pointed out how important research opportunities within the VA were in attracting and retaining health professionals who can provide services at the most advanced level of care to the veteran patient. In this regard, one of the budget casualties has been in the innovative program to support biomedical scientists, with either M.D. or Ph.D. degrees. Although originally planned to allow the recruitment of 200 physicians and 200 scientific doctorates, limited funding has prevented this program from reaching its target number of scientists.

The Program of Research and Development Related to Aging

On January 14, 1982 the Office of Research and Development cited 400 different projects for FY 1982 at 82 different facilities, as being concerned with the problem of the aging veteran. The listing included research centrally funded in the GRECCs and other merit reviewed research sponsored by the VA, the NIH and non-federal agencies, and including locally reviewed and locally sponsored projects. The decision as to what research has primary or secondary significance for the aging veteran can often be arbitrary. It could be argued, for example, that virtually any type of normative research on the young veteran is potentially of value for both longitudinal and cross-sectional studies of the aging veteran. Nevertheless, it is clear that the list includes many quite straightforward and important types of both gerontological and geriatric research.

In the discussion that follows only a few general remarks concerning that research can be made, as the Committee has not had the opportunity to personally evaluate these 400 projects. A few important general conclusions can probably be made, however. First of all, we can conclude, as documented in the discussion below on biomedical research, that the quality of merit reviewed VA-sponsored research on aging is on a par with other types of merit reviewed VA-funded research. Secondly, a very broad range of clincally relevant topics are being addressed. Thirdly, there appears to be an important and entirely appropriate emphasis upon aging of the central nervous system, much of it focused upon Senile Dementia of the Alzheimer's Type. Some important domains of research appear to be less well represented, however. Of great concern to the Committee is the paucity of Health Services Research. Moreover, there is evidence, elaborated below, that merit reviewed and funded VA investigators with certain highly relevant professional and discipline backgrounds rarely identify themselves as conducting programs with primary or secondary emphasis in the field of aging.

Biomedical and Psychosocial Research

As might be expected with a subject as diverse as gerontology and geriatrics, the research projects in aging being conducted in the VA system range widely, covering all of the major organ systems of the body and ranging from the molecular to the behavior levels of analysis. Some deal primarily with normative data essential for the development of biological and behavioral markers of the aging process, without which there can be little progress in the field. With the exception of one major study, such investigations are typically cross-sectional in design. Many are concerned with basic and/or clinical investigations of the major age-related diseases of man, including various dementias, Parkinson's disease, cerebro-vascular disease, senile macular degeneration, ocular cataracts, hearing loss, osteoporosis, osteoarthritis, adult onset diabetes mellitus, chronic obstructive pulmonary disease, various forms of arteriosclerosis (notably atherosclerosis), benign prostatic hyperplasia, amyloidosis and the major age-related carcinomas and lymphomas. The most concerted system-wide effort appears to involve a multi-faceted, multi-disciplinary investigation of the commonest age-related dementia of man, Senile Dementia of the Alzheimer Type. As of January, 1983, 25 VAMCs were active in this area including several of the GRECCs. Fifty-three VA investigators participated in such research, including 44 with program/projects centrally reviewed and centrally funded by the VA, one of whom has career development (cost center 108) funding.

Much of the disease oriented research, however, appears not to be strongly oriented along gerontological lines in which, for example, one designs experiments to ask about precise mechanisms by which the normal aging process sets the stage for a particular age-related disease, such as specific types of carcinoma.

There is good evidence that the quality of the merit reviewed, centrally funded research on aging, on the average, is comparable to those in other areas that are simultaneously reviewed by the various Merit Review Boards. This was ascertained by a statistical analysis of the priority scores for a sample of 37 investigators currently (February 1983) receiving 106G funds. Their mean priority score was 23.0 and that of the control was 24.9 ± 6.6 (std. deviation).

A sample of 118 investigators with merit reviewed and approved cost center 103 or 106 (FY83) grants was studied to determine the proportion of VA professionals of a given primary speciality area who self-report their primary or secondary program area of research as being in the field of aging. Only four (0.6%) of the 701 VA general internists with such research support indicated a primary research focus in aging; only 31 (4.4%) indicated a secondary program research focus in aging. Even less interest appears to exist among other categories of clinicians, notably neurologists, ophthalmologists and general surgeons. Only 6 (4.9%) of the 122 VA biochemists with such merit reviewed grants indicated a primary research focus in aging; only 4 (3.3%) indicated a secondary program research focus in aging. Even less interest appears to exist among other categories of basic scientists, notably immunologists, pathologists and physiologists.

Health Services Research

Health services research is viewed by the Committee as a general term that reflects an eclectic combination of a variety of applied health sciences. Research methods and data analysis strategies that are used within the framework of health services research include technology assessment, operations research, economics, clinical decision making, clinical epidemiology, and program evaluation, among others.

The Committee believes that health services research is mandated by P.L. 96-330 when it required each VA facility hosting a Geriatric Research, Education and Clinical Center to, "... develop the capacity to conduct effectively evaluations of the activities of such centers." Furthermore, the Geriatric Research, Education and Clinical Center hosting facilities were expected, "... to attract the participation of scientists who are capable of ingenuity and creativity in health care research efforts." This latter charge also appears not to have been met, to the extent that its intent included health services research scientists.

The current health services research program of approximately three million dollars is comprised largely by six field programs that have recently been funded. One program of $250,000 is located in each of the six VA regions, which provides some geographic distribution to the effort. Only one of these centers intends to concentrate on health services research specifically formulated to focus on the delivery of services to the aging veteran.

Judging from site visits to the eight centers of excellence in geriatric research (the GRECCs), and from an overview of the activities of the VA Health Services Research and Development Program, the Committee has arrived at several conclusions regarding the scope, quality and appropriateness of VA health services research efforts.

The level of effort of the health services research program is inadequate. Even within the Geriatric Research, Education and Clinical Centers Program, which is expected to demonstrate and evaluate new methods of delivering cost effective health services to the aged veteran, this mandate has not been fulfilled. Moreover, the expected benefit of these limited research efforts will be modest, although some projects appeared sound in their design and conduct. Thus, there seems to be no apparent overall guiding principles or purpose to the VA health services research activities.

Rehabilitation Research and Development

The goal of the VA program on Rehabilitation Research and Development is to improve the quality of life and functional independence in the activities of daily living for disabled, handicapped or aged veterans. Since this is a major goal of all enlightened programs in geriatrics, and since the enhancement of functional independence is a vital component of cost-containment in medical care, the Committee is greatly supportive of this program and has made some recommendations regarding its enhancement.

There are currently three priority areas: 1) prosthetics/amputation, 2) spinal cord injury and 3) sensory aids. The service estimates that some 54 projects, funded at a cost of $4,688,950 have significant impact on aging veterans. Included are five projects studying new devices and techniques in diagnosing peripheral ischemia at a cost of $365,759 in FY 1983; four projects studying new techniques and concepts in amputation surgery, at a cost of $370,683 in FY 1983; and six projects studying ambulation by amputees or hemiplegics to improve rehabilitation therapy, at a cost of $248,690 in FY 1983.

Fourteen projects study joint repair and/or replacement with new devices, new surgical techniques or evaluating materials and procedures ($1,010,877 in FY 1983). Several projects are currently funded in which new technologies, such as computer-generated voice techniques, are being developed and evaluated to assist blinded veterans.

The largest single disability category in the VA is hearing impairment, affecting some 180,000 eligible veterans. Nine projects are currently studying improved diagnosis of hearing loss and new devices to reduce the communication loss.

SUMMARY AND CONCLUSIONS

At present there are 3.5 million veterans over the age of 65. By the year 2000 there will be approximately 9 million veterans who will account for two out of every three American males in that age group. Most of these veterans saw service in World War II. Four million will be above 75 years of age and a half million of these, more than 85 years old. Because utilization of health care services is age related, a marked increase in the utilization of health care services can be anticipated from these demographic changes.

The future patterns of health care utilization will be a function of a number of factors. For the VA specifically, one such factor is the economic climate in the country and the related level of health care coverage generally afforded the average citizen, whether through Medicare or other governmental programs, or private means. A second critical factor is the model of delivery of care available to an aging veteran who is likely to have chronic and debilitating illness. It is increasingly apparent that the quality of older citizens' lives can be enhanced by keeping them active in their own homes and communities.

To assess the VA response to the imminent influx of older patients into its health care system, attention must be focused on several themes:

- The need to supplement the current system of care with a wide array of chronic care resources coordinated with community resources,
- The need for health professionals in all disciplines, trained in geriatrics and gerontology, who can enter into an interdisciplinary mode of team care,
- The need for new knowledge about the basic processes of aging, both medical and psychosocial,
- The need to evaluate various patterns of care delivery and to identify barriers to the delivery of optimal care, and
- The need to allocate resources to maximize the quality of care in an equitable manner.

Finally, the Committee believes that the VA already has program initiatives which can have, if integrated and expanded, a positive impact on the care of the elderly veteran.

The GRECC Program is a logical component of this evolving system. It has had and will have a positive impact. The Physician Geriatric Fellowship Program is already supplying high caliber leadership to the system. The Interdisciplinary Team Training in Geriatrics Program is experimenting with new modes of care delivery. The Nursing Scholarship Program and the Geriatric Fellowship Program in Dentistry are guiding talent toward an interest in care of the aging veteran. These efforts must be supported and expanded at a rate and to a degree commensurate with the changing demography of the veteran population.

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APPENDICES

APPENDIX A

GERIATRICS AND GERONTOLOGY ADVISORY COMMITTEE

BIOGRAPHICAL SKETCHES

Appendix A

GERIATRICS AND GERONTOLOGY ADVISORY COMMITTEE

CHAIRMAN

EWALD WILLIAM BUSSE, M.D., Sc.D., (Hon.), J. P. Gibbons Professor of Psychiatry, Dean Emeritus, Duke University School of Medicine, Durham, NC

A psychiatrist and pioneer researcher and educator in the field of aging, Dr. Busse has written extensively on medical aspects of that subject. His awards for research include the Brookdale Award (1982), the Seltzer Award (1975), the William C. Menninger Award (1971) and the Robert W. Kleemeir Award (1968). He has served on a number of National Institutes of Health councils and advisory training committees. He is a member of the National Academy of Science Institute of Medicine.

RICHARD C. ADELMAN, Ph.D., Director, Institute of Gerontology, University of Michigan, Ann Arbor, MI

A noted biochemist who has written extensively on the aging process, Dr. Adelman is the editor-in-chief of the Handbook Series on Aging, five volumes of which are in press (CRC Press). He has served on numerous committees of the Gerontological Society, National Institutes of Health study sections and on the National Academy of Sciences Committee on Animal Models for Research on Aging. He is a recipient of the Intrascience Research Foundation's Medalist Award (1977).

JACK BOTWINICK, Ph.D., Professor of Psychology, Washington University, St. Louis, MO

An authority on aging and behavior, Dr. Botwinick is a frequent contributor on this subject to academic journals. His most recent book, We Are Aging, was published in 1981 by Springer Publication Co., of New York. In 1979, he received the Kleemeir Award of the Gerontological Society for meritorious research in gerontology. He has served on numerous National Institutes of Health Advisory Committees.

CHESTER WILLIAM DOUGLASS, D.D.S., M.P.H., Ph.D., Chair, Department of Dental Care Administration, Harvard School of Dental Medicine, Boston, MA

A noted dental researcher, Dr. Douglass has been active in health policy for long-term care for the American Public Health Association, and the Massachusetts Dental Society. As a Robert Wood Johnson Health Policy Fellow in 1975-76, he served as a U.S. Senate health staff aid. He was the Staff Director from 1977 to 1980 for the study "Public Policy Options for Better Dental Health" for the Institute of Medicine of the National Academy of Sciences.

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REV. MSGR. CHARLES J. FAHEY, Marie Ward Doty Professor in Aging Studies and Director of the Third Age Center, Fordham University, New York, NY

The Rev. Msgr. Fahey has served on numerous committees dealing with aging, including the Federal Council on Aging (since 1974) which he chaired in 1980-1981. He has been President of the National Conference of Catholic Charities and the American Association of Homes for the Aging. He chaired the session on Long Term Care in the 1971 White House Conference on Aging and chaired the technical committee on Long Term Care for the 1981 White House Conference. Currently he chairs the Task Force on Aging of the National Association of Social Workers. He is active in New York State in various matters chairing the New York City Department of Aging Advisory Committee as well as being a member of the New York State Public Health Council.

ROBERT KATZMAN, M.D., Professor and Chair, Department of Neurology, Albert Einstein College of Medicine, New York, NY.

A widely recognized neurologist, Dr. Katzman has been a frequent contributor of scientific articles to medical journals in the field for almost 30 years. He has published extensively on Alzheimers Disease, a major factor in the institutionalization of the elderly. He has served on the National Institutes of Health Aging Review Committee and Advisory Council and is Chair of the Medical and Scientific Advisory Board of the Alzheimer Disease and Related Disorders Association.

ROBERT EDWARD LYNGH, Director, National Veterans Affairs and Rehabilitation Commission, American Legion, Washington, DC

A consumer member of the GGAC, Mr. Lyngh has been active in the American Legion since 1945. Prior to assuming his present position, he served as American Legion Assistant National Adjutant from 1956 to 1967. He served in the U.S. Army Air Force in the European Theater from 1942 to 1945.

FLORENCE MAHONEY, Washington, DC

A charter member of the National Advisory Council on Aging, Ms. Mahoney is a private citizen who has compiled a record of more than 30 years' service in helping to shape national health science policy; much of it related to health problems of the elderly. She is a member of the Board of Governance of the Veterans Administration, and among many other bodies has served on the President's Commission on Heart Disease, Cancer and Stroke and the National Arthritis, Metabolism and Digestive Diseases Advisory Council.

GEORGE M. MARTIN, M.D., Professor of Pathology, Adjunct Professor of Genetics, University of Washington, Seattle, WA

Dr. Martin is widely known for his research into the genetics of aging. His contributions to biomedical research span almost three decades. He has co-authored two recent books on aging: Structural Pathology of DNA and the Biology of Aging (Freiburg, 1980); and Biological Theories of Aging (NIA, 1980). He has served on many National Institutes of Health advisory committees throughout the years. He received the Josiah Macy Jr. Foundation Faculty Scholar Award for the 1978-1979 academic year for research at the Dunn School of Pathology, Oxford University. He is also a recipient of the Brookdale Award of the Gerontological Society of America.

IDA MARIE MARTINSON, Ph.D., M.N.A., Professor and Chairperson, Family Health Care Nursing, University of California at San Francisco, San Francisco, CA

Dr. Martinson, physiologist and noted nurse-scientist, has written extensively on nursing's role in health care delivery. She has studied the health care delivery system in Taiwan, Republic of China, as well as the care of the elderly in mainland China. She has served on the National Institute on Aging's Advisory Council since 1980. She is a member of the Institute of Medicine of the National Academy of Sciences (1981).

FRANK BARTLETT McGLONE, M.D., Associate Clinical Professor of Medicine, University of Colorado Medical School, and Executive Director, Medical Care and Research Foundation, Denver, CO

Dr. McGlone is widely respected for his contributions to clinical geriatric medicine. A founding member of the Denver Clinic, he has published extensively, including Health Habits in Relation to Aging (1978). He was presented the Rudolf Schindler Award by the American Society of Gastrointestinal Endoscopy (1971). He has been a member of the Board of Directors of the American Geriatrics Society since 1978 and was elected President for 1981-1982.

ETHEL SHANAS, Ph.D., Professor Emerita of Sociology and Professor Emerita of Health Care Services, University of Illinois, Chicago, IL

Dr. Shanas is a noted authority on the social aspects of aging. She has written widely in the field of aging and is the co-editor of the Handbook of Aging and the Social Sciences (Van Nostrand Reinhold, 1976). She is a member of the Institute of Medicine of the National Academy of Sciences (1979), and has served on the Committee on Aging of the National Research Council. She has received the Kleemeir Award and the Brookdale Award of the Gerontological Society of America, the Keston Award of the University of Southern California, and the Burgess Award of the National Council on Family Relations.

MARC EDWARD WEKSLER, M.D., Wright Professor of Medicine, Cornell University Medical College, and Director, Division of Geriatrics and Gerontology, New York, NY

Dr. Weksler is an authority on the immune system and aging. His recent contributions to literature include "Autoimmunity," and "The Immune System and the Aging Process in Man." He has written many articles on the subject for medical journals. He served on the National Institutes of Health Aging Review Committee from 1975 to 1979.

THOMAS FRANKLIN WILLIAMS, M.D., Professor of Medicine, University of Rochester, and Medical Director, Monroe Community Hospital, Rochester, NY

Dr. Williams is well known for his expertise in the field of geriatric clinical practice. During his distinguished career he has been selected Markle Scholar in the Medical Sciences (1957-62); Diplomate, American Board of Internal Medicine (1964); and L. S. McLeod Visiting Professor of Geriatric Medicine, University of Adelaide and South Australia Postgraduate Medical Education Association (1977). He is a member of the Institute of Medicine of the National Academy of Sciences (1976), the Royal Society of Medicine, London (1980), and has published extensively in the area of aging. On July 1, 1983, Dr. Williams will assume the position of Director of the National Institute on Aging of the National Institutes of Health.

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APPENDIX B

GERIATRIC RESEARCH, EDUCATION AND CLINICAL CENTER PROGRAM REPORT

GERIATRICS AND GERONTOLOGY
ADVISORY COMMITTEE

INTERIM REPORT

THE VETERANS ADMINISTRATION'S
GERIATRIC RESEARCH, EDUCATION AND
CLINICAL CENTER PROGRAM

January 1983

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I. INTRODUCTION

The Veterans Administration Health-Care Amendments of 1980, Public Law 96-330, codified at 38 U.S.C. 4101 (f), was enacted by Congress on August 26, 1980. The stated purpose of Title III of that act, entitled "Geriatric Research and Care," Section 301, was "(1) to improve and expand the capability of the Veterans Administration health-care facilities to respond with the most effective and appropriate services possible to the medical, psychological and social needs of the increasing number of older veterans, and (2) to advance scientific knowledge regarding such needs and the methods of meeting them by facilitating higher quality geriatric care for eligible older veterans through geriatrics and gerontological research, the training of health personnel in the provision of health care to older individuals, and the development of improved models of clinical services for eligible older veterans."

Section 302 of Public Law 96-330 was related to the Veterans Administration Geriatric Research, Education and Clinical Centers (GRECC) and to the Geriatrics and Gerontology Advisory Committee (GGAC). The Veterans Administration GRECC program was initiated in 1974. Eight such centers are currently active. Section 302 of the law provides that the Administrator upon the recommendation of the Chief Medical Director "shall designate not more than fifteen Veterans' Administration health-care facilities as the locations" for the geriatric research, education and clinical centers "(subject to the appropriation of sufficient funds for such purpose)." In addition to the authorization to create a limited number of geriatric centers, the act identified conditions which must be met for a VA health-care facility to be designated as operating a GRECC.

Section 302 of the law provides generally (with pertinent provisions quoted) that the host health care facility has:

(i) "an arrangement with an accredited medical school which provides education and training in geriatrics" and under which residents rotate through the GRECC and through nursing home, domiciliary or extended care units or programs;

(ii) "an arrangement under which nursing or allied health personnel" rotate, to receive training and education, through nursing home, extended care or domiciliary units;

(iii) "the ability to attract the participation of scientists" capable of ingenuity and creativity in health-care research;

(iv) "a policy-making advisory committee, composed of VA and affiliated university professionals, to advise the facility and GRECC directors on policy matters related to the GRECC activities; and

(v) "the capability to conduct effectively evaluations" of the GRECC activities.

The law also stipulated that the VA assure an appropriate geographic distribution of GRECC-host facilities.

Following the specific stipulations related to GRECCs, Congress in Public Law 96-330 directed the establishment of the Geriatrics and Gerontology Advisory Committee. The law provided that the Committee was to be composed of individuals with interest and expertise in the area of aging who were not employed by the federal government. At least one member of the GRECC was to be a representative of a national veterans' service organization.

Pertinent provisions of Section 302 are quoted below outlining the charge to the Committee:

(i) "advise the Chief Medical Director on all matters pertaining to geriatrics and gerontology;

(ii) "assess through an evaluation process," the geriatric research, education and clinical centers;

(iii) "assess the capability of the Veterans' Administration to provide high quality" health-care services to eligible older veterans;

(iv) "assess the current and projected needs of eligible older veterans" for health-care services from the VA and its activities and plans to meet those needs; and

(v) "perform such additional functions as the Administrator or Chief Medical Director may direct."

The GGAC was directed to submit a report to the Administrator of Veterans Affairs, through the Chief Medical Director, regarding its findings and conclusions. The report was directed to be presented not later than April 1, 1983 and was to include:

- a description of the operations of the GRECCs;
- an assessment of the quality of the operations of the GRECCs;
- an assessment of the extent to which the VA is meeting the needs of eligible older veterans for health-care services;
- assessment of deficiencies, and recommendations for correcting deficiencies in the operations of the GRECCs; and

- recommendations regarding other services might be required to meet the needs of older veterans.

The Committee may also submit in the same manner any other reports that it considers appropriate to its charge.

Recognizing the interest on the part of both the VA and the Congress in the Committee's assessment of GRECCs, coupled with the GGAC's own sense of responsibility to provide information regarding the GRECCs to the Veterans Administration in as timely a manner as possible, the Committee is submitting this interim report related to those aspects of its charge applicable to the GRECC program. In April 1983, the Committee will submit a report that will assess the capability of the VA to provide high quality care to eligible older veterans and will assess the older veterans' current and projected needs. The report will address the VA remedial activities and plans designed to meet these needs. Furthermore, pursuant to the directives of the law, the report will review the health and care needs of aging veterans and will comment upon relevant research, training of personnel and the provision of services to the older veterans.

This interim report will present the procedures and activities of the Committee, and the Committee's observations, findings and recommendations regarding the GRECC program. Recommendations to enhance the operation of this program have been conveyed to the Chief Medical Director for his consideration.

II GERIATRICS AND GERONTOLOGY ADVISORY COMMITTEE

A. Membership

The GGAC was established in January 1981, with members receiving official appointment in May 1981. Members of the Committee were selected for their professional expertise, knowledge and experience in the field of geriatrics and gerontology. A list of members and short biographical sketches appear in the appendices. A full curriculum vitae for each member is on file in the VA Department of Medicine and Surgery (DM&S).

B. Orientation

The first meeting of the Committee was held in Washington, DC on May 21-22, 1981. The Committee was briefed by and interacted with high-level program officials in the department regarding DM&S's programs and plans for providing health care services to eligible older veterans. During those meetings the Committee learned that the VA has recognized the need to plan medical care for the veteran portion of an increasingly aging population. Historically, this planning effort was complicated by several factors: first, a lack of appreciation on the part of the general public and professional health-care providers of the need to plan and provide care for large numbers of aging people; and second, the difficulty in reliably forecasting the number of veterans the VA might be called upon to care for, given that many other factors will mediate the dimensions of that demand.

The VA, responding to these pressures, created two new programs. The GRECC program created centers that were "to achieve professional legitimacy by attracting outstanding professionals to teach and to conduct research on aging in a clinical context and, as a result, have a positive impact on the care of the older veteran patients."[1] Between 1974 and 1977 in cooperation with medical schools, eight such centers had been designated as Geriatric Research, Education and Clinical Centers (GRECC). In 1977, the VA began to develop a geriatric fellowship program for July 1982 to include a geriatric fellowship program for dentists. The Committee recognizes the far-reaching effect these actions have had and commends the VA for these early efforts.

In 1977, a report was developed by the DM&S.[2] This report, developed at the direction of Congress (Public Law 94-581), was based upon data collected by the VA that was important in determining the short-range and long-range need of the aging veterans and in providing direction of hospital and medical programs for veterans.

Prior to beginning the site visits to the GRECCs, the Committee also examined the reports and recommendations generated by an internal assessment team which visited the GRECCs during 1979-1980. In addition, Committee members visited VA facilities which were not designated as hosting GRECCs to observe and compare health-care services for the elderly veteran.

C. Site Visit Procedure

The Committee conducted the site visits of the GRECCs over a seven-month period. The schedule of visits appears in the appendices.

At each facility, the Committee met with the Director, the Chief of Staff, selected service chiefs, the GRECC staff members, geriatric fellows, residents, officials of the affiliated medical school, veterans organization representatives, and, in two instances, some staff members of Regional Medical Education Centers (RMECs). Committee members also visited clinical units and heard presentations on research projects. Portions of the report were written by individual Committee members. The report was discussed, revised and edited. This report has been approved by all members of the Committee.

VA staff members from Washington who accompanied the committee on the site visits were:

Susan J. Brennan, Acting Director, Development and Management Service, Office of Geriatrics and Extended Care;

Mrs. Barbara J. Pryor, Special Assistant to the Chief Medical Director;

Dr. Phillip T. White, Associate Deputy Chief Medical Director for Program Management

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[1] Geriatric Research, Education and Clinical Center Program Evaluation, Department of Medicine and Surgery, Office of Extended Care, April 1980, page 1 of Introduction.

[2] The Aging Veteran: Present and Future Needs, Veterans Administration, October 1977.

A special vote of thanks is due to the facility Directors, their staffs and the staffs of the GRECCs for their assistance and understanding during the site visit proceedings.

III FINDINGS

A. Overview

The GRECC program was established in the VA system in 1974 with broad goals and objectives to allow for a center to focus upon areas of inquiry of importance to aging and the VA. The VA wisely chose to establish the centers in a variety of settings, all affiliated with a number of schools such as medical, dental, nursing and other health professions. The settings include acute and long-term care facilities and one center is connected with an independent outpatient clinic.

The Committee believes there is considerable merit in establishing the GRECCs in different types of facilities and in taking advantage of particular strengths of individual medical centers. The delivery of cost effective health care is a major concern of the VA. A variety of operational models will provide comparative evaluations.

Progress in the GRECC program has been encouraging, although it is not uniform in each of the GRECCs. Problems exist in the GRECCs and in the host facilities in achieving the diverse requirements set forth in the 1980 law. The Committee recognizes the difficulty in satisfying these assigned responsibilities in the face of limited resources and limited time.

The Committee found that the degree of success of any one center was primarily determined by the professional and leadership qualities of the Director and by the constructive support of the administration of the host facility. Other important ingredients were adequate space and personnel, the mission and geographic location of the host facility, and the strength of the affiliations with colleges and universities.

The GRECC program at its inception was intended to emphasize aging research. Consequently, in most centers, the Director is a reputable basic scientist or clinical investigator. This pattern of leadership selection should be continued.

The Committee observed that the limited size of the GRECC core staff made it difficult, if not impossible, to initiate and maintain the various programs pertinent to the aging veteran. High priority programs include high quality research, education and clinical services. Other programs of considerable value are concerned with community cooperation, "out reach" activities, collaboration with other GRECCs and the utilization of the VA as a comprehensive health-care system and as a communication network.

The GRECCs, as currently constituted and staffed, and given the current limitations in funding, have great difficulty in successfully carrying out all their missions under the 1980 law. Despite these limitations, however, they seem to be operating reasonably effectively. The GRECC staffs are enthusiastic, although small in number, and the facilities in which the GRECCs are located are generally supportive. Implementation of the objectives of the GRECC programs vary from site to site. The Committee evaluated performance of the GRECCs in light of their original stated objectives and the criteria as specified in the law.

B. Administration

The central administration of the VA and the Assistant Chief Medical Director for Geriatrics and Extended Care have helped to formulate and have supported the growth of the GRECCs. The enthusiasm that was required for initiating the eight GRECCs was not paralleled by new administrative procedures for surveillance and guidance. In 1974 there were few guidelines developed for the GRECC program as an integrated whole. VA Central Office has been responsive to local initiative and has awarded GRECCs to the best applications that were offered. While the Committee recognizes the value of building upon the strengths of local program talent, it believes there should be some clear central procedure for periodic review and fiscal accountability. The Committee believes, however, that centrally directed guidance should not be limiting or constricting. Specific areas where Central Office could provide general assistance are planning, program guidelines, model configuration and testing, and audit and review.

Of great concern to the Committee was the fact that despite previous critical reviews of individual GRECCs the recommended actions of the internal evaluating team frequently were not implemented. For this reason the Committee, on repeated occasions, found the problems identified in their reviews to be similar or identical to those reported previously by another site visit team. A stronger hand in formulating a balanced GRECC program and in assuring the correction of identified shortcomings in programs is necessary in VA Central Office.

The Committee was particularly interested in the function and composition of the local GRECC Advisory Committees. There appeared to be considerable variation in the Advisory Committees from one site to another. In some instances, the GRECC Advisory Committee seemed to have very little to do with policy matters related to the GRECC, and in other sites, the key health professionals in aging, either at the affiliated university or at the host VA facility, were not represented on the Committee. The GGAC believes that VA Central Office should review that portion of Public Law 96-330 related to the composition and activities of advisory committees of a GRECC, and that it should provide guidance to the individual GRECCs which would allow them to make those Committees more useful while consistent with the law.

The Committee observed considerable variability from site to site in both the quality and degree of development of the research, education and clinical components of the GRECCs. In addition, within each site the interrelationship among the research, education and clinical components was not always clear to the Committee. With respect to decision making and resource allocation, it appeared to the Committee that the decisions or preferences of the GRECC Director could only be implemented in a climate where both the Chief of Staff and the host facility Director were supportive of the GRECC program. One final observation related to the administration of the GRECC program arises from the Committee's belief that the failure of the VA to provide increased administrative support when incremental research awards are received by the

GRECCs is an impediment to program development.

C. Research

Research is conducted in the VA by approximately five thousand scientists located throughout the system of health-care facilities, and is funded from a variety of sources. The VA's intramural funding program, under the auspices of the VA Central Office, considers merit review of research proposals twice a year and proposals are subject to approval by appropriate committees of external scientific specialists before they can be funded. VA investigators also compete for funds from other federal agencies, pharmaceutical companies, and private foundations. Research in VA medical centers may be conducted independently or in collaboration with an affiliated academic institution. The Committee noted the obvious difficulties in achieving a good working relationship with existing research programs in the affiliated institutions. Progress toward improving those relationships does appear to be satisfactory.

Aging has been designated as a 106G high priority research area in the VA. Research programs are designated as 106G when:

- a member of the GRECC professional staff submits a research program focused on aging and receives an approval from the merit review board reviewing the proposal, or

- an investigator from the host VA facility submits a research program which is approved through the merit review process and is related to the research focus of the GRECC.

In addition to assessing the scientific merit of a research proposal, the merit review boards assign priority scores which have direct impact upon the amount of funding of the research program. The range of the priority program is from a high of 10 to a low of 50. Applications with scores under 15 receive full funding of the recommended budget. Applications with scores from 15 to 34 receive 70 percent funding of the recommended budget, while applications with scores 35 and higher receive no funding. The 106G programs are treated differently as they receive full funding if they have a priority score between 15 and 34. Research initiated by the GRECCs often falls into this category.

While the Committee recognizes and appreciates the efforts of the VA to establish aging as a high priority research program, it is concerned, nonetheless, with a number of aspects of the GRECC research program. They are presented below:

- The quality of research at a GRECC and within the GRECC program was uneven. Some GRECCs have generally good to excellent research programs in aging; in other instances, specific projects were of questionable merit. These have been called to the attention of the Chief Medical Director.

- Clinical and evaluation research in the GRECCs should be expanded. The VA's organized patient care system provides an opportunity for clinical and health services research. The relative lack of evaluation research related to alternative ways of providing cost effective care was particularly disappointing.

- There are similar research projects being conducted within the various GRECCs and improved communication would maximize the value of such parallel projects. It was the Committee's observation that very real attempts to improve communications between the GRECCs have begun.

  The existence of the VA system's large data base is a demonstrated resource and cooperative studies involving the GRECCs should be encouraged to capitalize upon this asset.

- Since the GRECCs are relatively small, adequate core research funding to replace and modernize equipment is a need of concern to the Committee. The Committee recognizes the difficulty in creating and maintaining a critical mass of equipment and supplies when the fiscal constraints are so real.

- The Committee has observed inadequate planning in some sites for the requisite support services (such as space, animal facilities) for an adequate research program. If the individual GRECCs and their host facilities are going to attract high caliber scientists to the programs, there must be plans to provide adequate facilities and support services.

D. Education

The Committee supports the view that the educational mandate of the GRECCs is broad and that innovation should be encouraged. While Public Law 96-330 singles out the educational mission of the GRECCs to physicians and allied health professionals, such a directive does not preclude other activities. The Committee observed educational programs in varying stages of planning or implementation at the different GRECC sites. In some sites GRECC offered continuing education experiences for health professionals on the staff of the host facility, in other locations GRECC staff were actively involved in educational programs oriented towards the families of their patients. Some of the GRECCs were involved in cooperative educational ventures with other community agencies and others were sending GRECC staff to other VA medical centers within their region to conduct continuing education programs for the personnel at these facilities.

The effective participation of the affiliated medical schools in GRECC activity is not uniform, some being more active than others. In several instances the schools credited the VA for stimulating them to deal with geriatric issues. The VA has on occasion provided the faculty support necessary through both GRECC and non-GRECC resources to establish divisions or programs of geriatrics within the schools. These initiatives represent outstanding contributions toward the future development of the field, and will benefit veterans and their families.

The roles of GRECC personnel within the affiliating schools vary greatly and although most GRECC personnel have appropriate faculty appointments, efforts should continue to ensure that all appropriate professional personnel receive faculty appointments which reflect their academic qualifications and contributions.

The VA's Physician Geriatric Fellowship Program seems to have been singularly successful. Five of the twelve programs are associated with GRECCs and, while designated as host facility programs, they are conducted by and in the GRECCs. The Committee believes that the presence of these talented young physicians, although few in number, has served to catalyze interest in and respect for the geriatric patient among hospital personnel. It is expected that the same positive outcomes will begin to accrue from the addition of the dentists' geriatric fellowship program.

The Committee recognizes that the educational component within the eight GRECCs represents a small, but essential part of the total commitment of the VA to education and training. Close to 100,000 students at all levels from educational institutions receive clinical training each year in VA facilities. In fiscal year 1982, 7,615 residency slots in a wide range of specialties were allocated to 120 affiliated VA facilities. Of the 172 VA medical centers, 133 are affiliated with 100 medical schools, 75 with 52 dental schools, and all VA medical centers are affiliated with one or more nursing and associated health schools and/or health training programs in over 1,000 different institutions. The teaching of geriatrics is expanding and is an important factor in the care of the elderly veteran and to the aged in general. It is noted, however, that involvement with schools of nursing at the graduate level appears limited. The Committee believes that nursing plays a vital role in geriatric care and that graduate-level students would enhance the delivery of nursing services in the VA. Especially critical is the recruitment of nurse investigators for the GRECCs.

The VA DM&S also operates a large continuing education program for its 188,000 employees. The program is operated partially through the VA's seven Regional Medical Education Centers (RMECs). These centers are dedicated to education and training of VA employees. The centers are staffed with educational experts and have access to a wide range of audiovisual capabilities. This expertise can be and is made available to the GRECCs and, in like manner, specialists in the GRECCs participate with the RMECs in presenting continuing education programs. Cooperation existed in those two sites where both a GRECC and RMEC were located.

E. Clinical Care

Just as the Committee observed great variation in the research and educational components of the various GRECCs, it noted variation in both the types and the quality of the GRECC clinical programs. Several of the clinical programs are innovative and appear to be effective models for patient care, but need to be evaluated. For example, one GRECC developed an outpatient program that interfaced with its educational program. The innovative character of this clinical program relates to community, including family service. This unique program should be given additional attention. A second GRECC focused on the very old veteran providing personalized attention and service. The medical care program at this site was broad in its attention to patient needs, yet specific in its response to the immediate problem at hand. Another GRECC clinical program admitted long-term care patients with Alzheimer's disease for both study and care. Short-term beds were made available to patients and families were counseled and given assistance when possible. While the treatment program itself was not unusual, the admission for short-term care of such patients is unique within the VA. The study of such patients and the relief provided to the family may be a valuable model for extending VA care beyond the confines of the health-care facility.

Although many of the GRECCs have set up geriatric evaluation units, only one has a formal procedure to evaluate the clinical impact of the evaluation unit. The frequent lack of evaluation procedures was a disappointment to the Committee. We are particularly concerned that there are limited attempts to evaluate the cost effectiveness of new approaches and their application to large clinical programs.

The clinical component of the GRECC is modest but is growing. Depending upon the stage of development of the clinical program, it may or may have included a separate bed service for the GRECC, consultation by GRECC staff to other clinical services within the host facility, and/or the provision of outpatient care. All of the GRECC clinical programs seem to be utilizing configurations of multidisciplinary teams composed of nurses, physicians and other professionals. The Committee was particularly concerned with the defects in developing clinical services associated with GRECCs. A strong clinical service integrated into the GRECCs provides a base for clinical research, education, and training of health professionals. The Committee believes it is appropriate to provide an additional GRECC budget allocation to support the clinical demonstrations and evaluations in order to integrate and support more fully a comprehensive research, education and clinical care program.

IV. SUMMARY AND RECOMMENDATIONS

The Committee believes that the GRECC program is a logical component of the VA and that the program has had and will have a positive impact on the care of the elderly veteran. The idea that GRECCs would stimulate VA interest in geriatrics and the special problems of aging appears well founded in the VA. While the GRECCs are staffed primarily by individuals of talent and dedication, limited resources have made it difficult for them to fulfill all the required responsibilities (P.L. 96-330) in the areas of research, education, and clinical care.

The Committee believes, however, that the maintenance of aging research activities is of great importance. Research offers the greatest hope for substantial improvement in the quality of life of aging veterans and their continued participation as productive citizens. Research in fundamental processes of aging may hold the key to containment of the rapidly rising costs associated with the major age-related disorders of man, including senile dementia of the Alzheimer's type, various forms of arteriosclerosis, maturity onset diabetes mellitus, osteoporosis, pulmonary emphysema, benign prostatic hyperplasia and the common carcinomas and lymphomas. The Committee believes that a well funded, well integrated, comprehensive research, education and clinical program specific to geriatrics holds great promise in addressing these critical issues.

We therefore recommend that:

a. DM&S should re-examine the expectations and limitations affecting the GRECCs and host facilities as set forth in P.L. 96-330. If GRECCs are aggressively and equally to undertake research, education and clinical care, greater resources will be necessary.

If a GRECC may be allowed to emphasize one or two of the components, the original structure may suffice. If necessary, DM&S should recommend a change in the law in order to reconcile the limited resources with realistic objectives.

b. More effective evaluation of the GRECC activities should be instituted both in the GRECCs themselves and in Central Office. The Central Office should establish a locus for leadership responsibility for the GRECCs. Administrative plans and procedures should be developed for an ongoing evaluation of the GRECC program. The VA should have in place a GRECC Evaluation Committee that includes non-VA members. Included in a periodic review should be a consideration of the merit of each research project, the research program as a whole, as well as the education and clinical components. Mechanisms should be established to assure that the deficiencies are corrected.

c. Research funding for the VA should not be diminished. Research in the GRECCs can only prosper to the extent that research funds are adequate for the VA's research program in general. Appropriate administrative funds should accompany incremental research funding to the GRECCs.

d. Health services research should be initiated to include the study of innovative models of care, including an evaluation of their cost effectiveness. To accomplish this and to meet other needs, it is necessary to train and recruit nurse investigators and other health professionals.

e. It is recommended that the VA develop a standard accounting procedure and report for designated GRECC funds. The annual report is to be prepared by the host facility of a GRECC and transmitted to VA Central Office.

APPENDICES

APPENDIX A

38 U.S.C. 4101

(f) (1) (A) The Administrator, upon the recommendation of the Chief Medical Director and pursuant to the provisions of this subsection, shall designate not more than fifteen Veterans' Administration health-care facilities as the locations for centers of geriatric research, education, and clinical activities and (subject to the appropriation of sufficient funds for such purpose) shall establish and operate such centers at such locations in accordance with this subsection.

(B) In designating locations for centers under subparagraph (A) of this paragraph, the Administrator, upon the recommendation of the Chief Medical Director, shall —

(i) designate each Veterans' Administration health-care facility that on the date of the enactment of the Veterans' Administration Health-Care Amendments of 1980 is operating a geriatric research, education, and clinical center unless, on the recommendation of the Chief Medical Director, the Administrator determines that such facility does not meet the requirements of subparagraph (C) of this paragraph or has not demonstrated effectiveness in carrying out the established purposes of such center or the purposes of title III of the Veterans' Administration Health-Care Amendments of 1980 or the potential to carry out such purposes effectively in the reasonably foreseeable future; and

(ii) assure appropriate geographic distribution of such facilities.

(C) The Administrator may not designate any health-care facility as a location for a center under subparagraph (A) of this paragraph unless, the Administrator, upon the recommendation of the Chief Medical Director, determines that the facility has (or may reasonably be anticipated to develop) —

(i) an arrangement with an accredited medical school which provides education and training in geriatrics and with which such facility is affiliated under which residents receive education and training in geriatrics through regular rotation through such center and through nursing home, extended care, or domiciliary units of such facility so as to provide such residents with training in the diagnosis and treatment of chronic diseases of older individuals, including cardiopulmonary conditions, senile dementia, and neurological disorders;

(ii) an arrangement under which nursing or allied health personnel receive training and education in geriatrics through regular rotation through nursing home, extended care, or domiciliary units of such facility;

(iii) the ability to attract the participation of scientists who are capable of ingenuity and creativity in health-care research efforts;

(iv) a policy making advisory committee composed of appropriate health-care and research representatives of the facility and of the affiliated school or schools to advise the directors of such facility and such center on policy matters pertaining to the activities of such center during the period of the operation of such center; and

(v) the capability to conduct effectively evaluations of the activities of such center.

(D) Prior to providing funds for the operation of any such center at a health-care facility other than a health-care facility designated under subparagraph (B)(i) of this paragraph, the Administrator shall assure that the center at each facility designated under such subparagraph is receiving adequate funding to enable such center to function effectively in the areas of geriatric research, education, and clinical activities.

(2) (A) The Administrator shall establish in the Department of Medicine and Surgery a Geriatrics and Gerontology Advisory Committee (hereinafter in this subsection referred to as the "Committee"). The membership of the Committee shall be appointed by the Administrator, upon the recommendation of the Chief Medical Director, and shall include individuals who are not employees of the Federal Government and who have demonstrated interest and expertise in research, education, and clinical activities related to aging and at least one representative of a national veterans' service organization. The Administrator, upon the recommendation of the Chief Medical Director, shall invite representatives of other appropriate departments and agencies of the United States to participate in the activities of the Committee and shall provide the Committee with such staff and other support as may be necessary for the Committee to carry out effectively its functions under this paragraph.

(B) The Committee shall —

(i) advise the Chief Medical Director on all matters pertaining to geriatrics and gerontology;

(ii) assess, through an evaluation process (including a site visit conducted not later than three years after the date of the establishment of each new center and not later than two years after the date of the last evaluation of those centers in operation on the date of the enactment of this subsection), the ability of each center established under paragraph (1) of this subsection to achieve its established purposes and the purposes of Title III of the Veterans' Administration Health-Care Amendments of 1980;

(iii) assess the capability of the Veterans' Administration to provide high quality geriatric, extended, and other health-care services to eligible older veterans, taking into consideration the likely demand for such services from such veterans;

(iv) assess the current and projected needs of eligible older veterans for geriatric, extended-care, and other health-care services from, the Veterans' Administration and its activities and plans designed to meet such needs; and

(v) perform such additional functions as the Administrator or Chief Medical Director may direct.

(C) (i) Not later than April 1, 1983, the Committee shall submit to the Administrator, through the Chief Medical Director, a report with respect to its findings and conclusions under subparagraph (B) of this paragraph. Such report shall include —

(I) descriptions of the operations of the centers of geriatric research, education, and clinical activities established pursuant to paragraph (1) of this subsection;

(II) assessments of the quality of the operations of such centers;

(III) an assessment of the extent to which the Veterans' Administration, through the operation of such centers and other health-care facilities and programs, is meeting the needs of eligible older veterans for geriatric and extended-care and other health-care services;

(IV) assessments of and recommendations for correcting any deficiencies in the operations of such centers; and

(V) recommendations for such other geriatric, extended-care, and other health-care services as may be needed to meet the needs of older veterans.

Following the submission of such report, the Committee shall also submit to the Administrator, through the Chief Medical Director, such further reports as the Committee considers appropriate with respect to the matters described in clauses (I) through (V) of the preceding sentence.

(ii) Not later than ninety days after receipt of a report submitted under division (i) of this subparagraph, the Administrator shall transmit such report, together with the Administrator's comments and recommendations thereon, to the appropriate committees of the Congress.

(3) There are hereby authorized to be appropriated for the basic support of the research and education activities of the centers of geriatric research, education, and clinical activities established pursuant to paragraph (1) of this subsection $10,000,000 for fiscal year 1981 and $25,000,000 for each of the next three fiscal years. The Chief Medical Director shall allocate to such centers from other funds appropriated generally for the Veterans' Administration medical care account and medical and prosthetics research account, as appropriate, such amounts as the Chief Medical Director determines appropriate and, with respect to fiscal year 1984, as the Chief Medical Director determines appropriate after taking into account the report submitted by the Committee under paragraph (2) of this subsection.

(4) Activities of clinical and scientific investigation of each center established under paragraph (1) of this subsection shall be eligible to compete for the award of funding from funds appropriated for the Veterans' Administration medical and prosthetics research account and shall receive priority in the award of funding from such account insofar as funds are awarded to projects for research in geriatrics and gerontology. (Added P.L. 96-330, § 302.)

APPENDIX B

VETERANS ADMINISTRATION

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VETERANS ADMINISTRATION

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Medical Center and Research Foundation
1565 Clarkson Street
Denver, Colorado 80218

12. **Ethel Shanas, Ph.D.**
222 Main Street
Evanston, Illinois 60202

13. **Marc E. Weksler, M.D.**
Professor of Medicine
Cornell University
525 E. 68th Street
New York, New York 10021

14. **T. Franklin Williams, M.D.**
Medical Director
Monroe Community Hospital
Professor of Medicine
University of Rochester
435 East Henrietta Road
Rochester, New York 14603

RICHARD C. ADELMAN, Ph.D., Director, Institute of Gerontology, University of Michigan, Ann Arbor, MI

A noted biochemist, who has written extensively on the aging process, Dr. Adelman is the editor-in-chief of the Handbook Series on Aging, five volumes of which are in press (CRC press). He has served on numerous committees of the Gerontological Society, National Institutes of Health study sections and on the National Academy of Sciences Committee on Animal Models for Research on Aging. He is a recipient of the Intrascience Research Foundation's Medalist Award (1977).

JACK BOTWINICK, Ph.D., Professor of Psychology, Washington University, St. Louis, MO

An authority on aging and behavior, Dr. Botwinick is a frequent contributor on this subject to academic journals. His most recent book, We Are Aging, was published in 1981 by Springer Publication Co., of New York. In 1979, he received the Kleemeir Award of the Gerontological Society for meritorious research in gerontology. He has served on numerous National Institutes of Health Advisory Committees.

EWALD WILLIAM BUSSE, M.D., Sc.D., (Hon.), J. P. Gibbons Professor of Psychiatry, Dean Emeritus, Duke University School of Medicine, Durham, NC

A psychiatrist and pioneer researcher and educator in the field of aging, Dr. Busse has written extensively on medical aspects of that subject. His awards for research include the Brookdale Award (1982), the Seltzer Award (1975), the William C. Menninger Award (1971) and the Robert W. Kleemeir Award (1968). He has served on a number of National Institutes of Health councils and advisory training committees. He is a member of the National Academy of Science Institute of Medicine.

CHESTER WILLIAM DOUGLASS, D.D.S., M.P.H., Ph.D., Chair, Department of Dental Care Administration, Harvard School of Dental Medicine, Boston, MA

A noted dental researcher, Dr. Douglass has been active in health policy for long-term care for the American Public Health Association, and the Massachusetts Dental Society. As a Robert Wood Johnson Health Policy Fellow in 1975-76, he served as a U.S. Senate health staff aid. He was the Staff Director from 1977 to 1980 for the study "Public Policy Options for Better Dental Health" for the Institute of Medicine of the National Academy of Sciences.

REV. MSGR. CHARLES J. FAHEY, Marie Ward Doty Professor in Aging Studies and Director of the Third Age Center, Fordham University, New York, NY

The Rev. Msgr. Fahey has served on numerous committees dealing with aging, including the Federal Council on Aging (since 1974) which he chaired in 1980-1981. He has been President of the National Conference of Catholic Charities and the American Association of Homes for the Aging. He chaired the session on Long Term Care in the 1971 White House Conference on Aging and chaired the technical committee on Long Term Care for the 1981 White House Conference. Currently he chairs the Task Force on Aging of the National Association of Social Workers.

He is active in New York State in various matters chairing the New York City Department of Aging Advisory Committee as well as being a member of the New York State Public Health Council.

ROBERT KATZMAN, M.D., Professor and Chair, Department of Neurology and Professor of Neuroscience, Albert Einstein College of Medicine, New York, NY

A widely recognized neurologist, Dr. Katzman has been a frequent contributor of scientific articles to medical journals in the field for almost 30 years. He has published extensively on Alzheimers Disease, a major factor in the institutionalization of the elderly. He has served on the National Institutes of Health Aging Review Committee and Advisory Council and is Chair of the Medical and Scientific Advisory Board of the Alzheimer Disease and Related Disorders Association.

ROBERT EDWARD LYNGH, Director, National Veterans Affairs and Rehabilitation Commission, American Legion, Washington, DC

A consumer member of the GGAC, Mr. Lyngh has been active in the American Legion since 1945. Prior to assuming his present position, he served as American Legion Assistant National Adjutant from 1956 to 1967. He served in the U.S. Army Air Force in the European Theater from 1942 to 1945.

FLORENCE MAHONEY, Washington, DC

A charter member of the National Advisory Council on Aging, Ms. Mahoney is a private citizen who has compiled a record of more than 30 years' service in helping to shape national health science policy; much of it related to health problems of the elderly. She is a member of the Board of Governance of the Veterans Administration, and among many other bodies has served on the President's Commission on Heart Disease, Cancer and Stroke and the National Arthritis, Metabolism and Digestive Diseases Advisory Council.

GEORGE M. MARTIN, M.D., Professor of Pathology, Adjunct Professor of Genetics, University of Washington, Seattle, WA

Dr. Martin is widely known for his research into the genetics of aging. His contributions to biomedical research span almost three decades. He has co-authored two recent books on aging: Structural Pathology of DNA and the Biology of Aging (Freiburg, 1980); and Biological Theories of Aging (NIA, 1980). He has served on many National Institutes of Health advisory committees throughout the years. He received the Josiah Macy Jr. Foundation Faculty Scholar Award for the 1978-1979 academic year for research at the Dunn School of Pathology, Oxford University. He is also a recipient of the Brookdale Award of the Gerontological Society of America.

IDA MARIE MARTINSON, Ph.D., M.N.A., Professor and Chairperson, Family Health Care Nursing, University of California at San Francisco, San Francisco, CA

Dr. Martinson, physiologist and noted nurse-scientist, has written extensively on nursing's role in health care delivery. She has studied the health care delivery system in Taiwan, Republic of China, as well as the care of the elderly in mainland China. She has served on the National Institute on Aging's Advisory Council since 1980. She is a member of the Institute of Medicine of the National Academy of Sciences (1981).

FRANK BARTLETT McGLONE, M.D., Associate Clinical Professor of Medicine, University of Colorado Medical School, and Executive Director, Medical Care and Research Foundation, Denver, CO

Dr. McGlone is widely respected for his contributions to clinical geriatric medicine. A founding member of the Denver Clinic, he has published extensively, including Health Habits in Relation to Aging (1978). He was presented the Rudolf Schindler Award by the American Society of Gastrointestinal Endoscopy (1971). He has been a member of the Board of Directors of the American Geriatrics Society since 1978 and was elected President for 1981-1982.

ETHEL SHANAS, Ph.D., Professor Emerita of Sociology and Professor Emerita of Health Care Services, University of Illinois, Chicago, IL

Dr. Shanas is a noted authority on the social aspects of aging. She has written widely in the field of aging and is the co-editor of the Handbook of Aging and the Social Sciences (Van Nostrand Reinhold, 1976). She is a member of the Institute of Medicine of the National Academy of Sciences (1979), and has served on the Committee on Aging of the National Research Council. She has received the Kleemeir Award and the Brookdale Award of the Gerontological Society of America, the Keston Award of the University of Southern California, and the Burgess Award of the National Council on Family Relations.

MARC EDWARD WEKSLER, M.D., Wright Professor of Medicine, Cornell University Medical College, and Director, Division of Geriatrics and Gerontology, New York, NY

Dr. Weksler is an authority on the immune system and aging. His recent contributions to literature include "Autoimmunity," and "The Immune System and the Aging Process in Man." He has written many articles on the subject for medical journals. He served on the National Institutes of Health Aging Review Committee from 1975 to 1979.

THOMAS FRANKLIN WILLIAMS, M.D., Professor of Medicine, University of Rochester, and Medical Director, Monroe Community Hospital, Rochester, NY

Dr. Williams is well known for his expertise in the field of geriatric clinical practice. During his distinguished career he has been selected Markle Scholar in the Medical Sciences (1957-62); Diplomate, American Board of Internal Medicine (1964); and L. S. McLeod Visiting Professor of Geriatric Medicine, University of Adelaide and South Australia Postgraduate Medical Education Association (1977). He is a member of the Institute of Medicine of the National Academy of Sciences (1976), the Royal Society of Medicine, London (1980), and has published extensively in the area of aging.

APPENDIX C

GERIATRIC RESEARCH, EDUCATION AND CLINICAL CENTER SITES

Bedford-Boston

Little Rock

Los Angeles (Wadsworth)

Minneapolis

Palo Alto

St. Louis

Seattle-American Lake

Sepulveda

APPENDIX D

SCHEDULE OF SITE VISITS

DATE	SITE
August 10-14, 1981	Los Angeles (Wadsworth)
	Sepulveda
November 16-18, 1981	Boston Outpatient Clinic
	Bedford
February 22-26, 1982	Palo Alto
	Seattle/American Lake
March 22-23, 1982	Minneapolis
	Little Rock
March 24-25, 1982	St. Louis

APPENDIX E

BEDFORD DIVISION GRECC

FY 1981

DIRECTOR: Michael J. Malone, M.D.

RESEARCH:

Focus on neurobiology of aging with a specific clinical focus on behavioral change in the elderly, including several projects on alcohol and aging.

GRECC RELATED RESEARCH BUDGET:

VA Funding	$ 97,000
Non-VA Funding	$ 93,000
TOTAL	$190,000

EDUCATION:

Physician Fellowship Program in Geriatrics.

Weekly GRECC grand rounds.

Weekly, bi-monthly and monthly clinical and/or research seminar series for VAMC staff and students.

CLINICAL CARE:

Inpatients	
Operating Beds	79
Patients Treated	1,379
Average Daily Census	77
Consultations	4/week
Outpatients	
Visits	25/week

VA MEDICAL CENTER
BEDFORD, MA
(617) 275-7500

Director:	Richard E. Nohe
Assistant Director:	William A. Mountcastle
Chief of Staff:	Charles G. Colburn, M.D.

BEDS (FY 81):

	Average Operating Beds	Average Daily Census	Occupancy Rate
Hospital:			
All Sections	748	688	92.0
Psychiatric	389	363	93.3
Surgical	22	18	81.8
Medical Total	337	307	91.1
Medical Intermediate	(279)	(261)	(93.5)
VA Domiciliary Care	N/A	N/A	N/A
VA Nursing Home Care	162	155	95.7
Community Nursing Home	N/A	71	N/A

PATIENTS TREATED (FY 81):

Inpatients		Outpatients	
VA Hospital	3,428	Medical Visits-Staff	104,326
Nursing Home Care		Dental Staff	
VA	208	Exams	273
Community	130	Treatment Cases Compl.	266

STAFF - FTEE as of 6/30/82:

1,265.9

BUDGET (FY 82):

$40,920,369

PRIMARY MEDICAL SCHOOL AFFILIATE:

Boston University School of Medicine

BOSTON OPC DIVISION GRECC

FY 1981

DIRECTOR: John W. Rowe, M.D.

RESEARCH:

Focus on mental performance and biochemistry: Memory and Learning Clinic and Endocrine-Behavior Clinic.

GRECC RELATED RESEARCH BUDGET:

VA Funding	$180,000
Non-VA Funding	$112,000
TOTAL	$292,000

EDUCATION:

Weekly Geriatric Colloquia.

Day-long seminar regarding health care of the older patient with diabetes.

CLINICAL CARE:

Clinic space undergoing renovation.

VA OUTPATIENT CLINIC
BOSTON, MA
(617) 223-2020

Director: Wilson J. Schuerholz
Assistant Director:
Chief of Staff:

BEDS (FY 81):

	Average Operating Beds	Average Daily Census	Occupancy Rate
Hospital:			
All Sections			
Psychiatric			
Surgical			
Medical Total			
Medical Intermediate			
VA Domiciliary Care			
VA Nursing Home Care			
Community Nursing Home			

PATIENTS TREATED (FY 81):

Inpatients

- VA Hospital
- Nursing Home Care
  - VA
  - Community

Outpatients

- Medical Visits-Staff
- Dental Staff
  - Exams
  - Treatment Cases Compl.

STAFF - FTEE as of 6/30/82:

BUDGET (FY 82):

PRIMARY MEDICAL SCHOOL AFFILIATE:

A OUTPATIENT CLINIC
BOSTON, MA
(617) 223-2020

Director:	Wilson J. Schuerholz
Assistant Director:	
Chief of Staff:	Eugene Record, M.D.

BEDS (FY 81):

	Average Operating Beds	Average Daily Census	Occupancy Rate
Hospital:			
All Sections			
Psychiatric	ENTIRE SECTION		
Surgical			
Medical Total	NOT APPLICABLE		
Medical Intermediate			
VA Domiciliary Care			
VA Nursing Home Care			
Community Nursing Home			

PATIENTS TREATED (FY 81):

Inpatients		Outpatients	
VA Hospital		Medial Visits-Staff	195,408
Nursing Home Care	NOT	- Fee	53,506
VA	APPLICBLE	Dental Staff	
Community		Exams	1,496
		Treatment Cases Compl.	1,360

STAFF - FTEE as of 6/30/82:

380.0

BUDGET (FY 82):

$19,357,048

PRIMARY MEDICAL SCHOOL AFFILIATE:

Harvard Medical School

Boston University School of Medicine

Tufts University School of Medicine

LITTLE ROCK GRECC

FY-1981

DIRECTOR: Eugene J. Towbin, M.D., Ph.D.

RESEARCH:

Focus is on the molecular biology of aging and health care delivery to the geriatric patient.

GRECC RELATED RESEARCH BUDGET:

VA Funding	$ 60,350
Non-VA Funding	$513,000
TOTAL	$573,000

EDUCATION:

Physician Fellowship Program in Geriatrics.

Interdisciplinary Team Training in Geriatrics Program.

Regularly scheduled GRECC Guest Visiting Lecture Series.

Weekly and monthly seminar and lecture series in geriatrics for VAMC staff and students.

House staff rotations through geriatric medicine and GRECC clinical unit.

CLINICAL CARE:

Inpatients

Operating Beds	37
Patients Treated	376
Average Daily Census	26
Consultations	225

Outpatients

Visits	804

VA MEDICAL CENTER
LITTLE ROCK, AR
(501) 372-8361

Director: Vincent J. Parrish
Assistant Director: Thomas A. Holthaus
Chief of Staff: Eugene J. Towbin, M.D.

THIS IS A TWO DIVISION MEDICAL CENTER — LITTLE ROCK AND NORTH LITTLE ROCK. WHILE THERE ARE GRECC UNITS IN BOTH DIVISIONS, THE GRECC IS PRIMARILY LOCATED IN THE ACUTE CARE HOSPITAL IN LITTLE ROCK.

ALL FIGURES ARE COMBINED MEDICAL CENTER FIGURES.

BEDS (FY 81):

	Average Operating Beds	Average Daily Census	Occupancy Rate
Hospital:			
All Sections	1,317	1,022	77.6
Psychiatric	551	444	80.6
Surgical	292	236	80.8
Medical Total	747	341	71.9
Medical Intermediate	137	106	77.4
VA Domiciliary Care	N/A	N/A	N/A
VA Nursing Home Care	200	192	96.0
Community Nursing Home	N/A	91	N/A

PATIENTS TREATED (FY 81):

Inpatients		Outpatients	
VA Hospital	19,303	Medical Visits-Staff	160,714
Nursing Home Care		Dental Staff	
VA	249	Exams	701
Community	262	Treatment Cases Compl.	623

STAFF - FTEE as of 6/30/82:

2,611.0

BUDGET (FY 82):

$94,901,404

PRIMARY MEDICAL SCHOOL AFFILIATE:

University of Arkansas College of Medicine

LOS ANGELES (WADSWORTH) GRECC

FY 1981

DIRECTOR: Takashi Makinodan, Ph.D.

RESEARCH:

Focus is on immunology of aging with the broad goals of elucidating the relationship between immunologic aging and susceptibility to infectious disease; developing predictive, non-invasive indices which can detect early signs of disease in the aged; and developing preventive and rehabilitative methods of controlling such disease progression.

GRECC RELATED RESEARCH BUDGET:

VA Funding	$337,000
Non-VA Funding	$425,000
TOTAL	$762,000

EDUCATION:

Physician Fellowship Program in Geriatrics.

Weekly, bi-monthly and monthly lecture and seminar series for VAMC staff, house staff and residents. Four-day symposium (national) related to New Perspectives to Sleep Research.

House staff and associated health professional student rotations through GRECC clinical unit.

CLINICAL CARE:

Inpatients

Operating Beds	13
Patients Treated	70
Average Daily Census	11
Consultations	160

Outpatients

Number Visits	600
Consultations	15

VA MEDICAL CENTER
WADSWORTH, LOS ANGELES, CA
(213) 478-3711

Director:	William K. Anderson
Assistant Director:	Lee N. Nackman
Chief of Staff:	Earl Gordon, M.D.

BEDS (FY 81):

	Average Operating Beds	Average Daily Census	Occupancy Rate
Hospital:			
All Sections	710	501	70.6
Psychiatric	N/A	N/A	N/A
Surgical	223	145	65.0
Medical Total	487	356	73.1
Medical Intermediate	(165)	(120)	(72.7)
VA Domiciliary Care	400	323	80.8
VA Nursing Home Care	N/A	N/A	N/A
Community Nursing Home	N/A	96	N/A

PATIENTS TREATED (FY 81):

Inpatients		Outpatients	
VA Hospital	15,847	Medical Visits-Staff	205,723
Nursing Home Care		Dental Staff	
VA	397	Exams	524
Community	629	Treatment Cases Compl.	394

STAFF - FTEE as of 6/30/82:

2,534.7

BUDGET (FY 82):

$98,415,054

PRIMARY MEDICAL SCHOOL AFFILIATE:

UCLA School of Medicine

MINNEAPOLIS GRECC

FY 1981

DIRECTOR: Gabe J. Maletta, Ph.D., M.D.

RESEARCH:

Focus is on developing an integrated fundamental and applied research program involved with functional changes in the aging nervous system, particularly those associated with progressive organic intellectual impairment and motor dysfunction (including Alzheimer and Parkinson disease).

GRECC RELATED RESEARCH BUDGET:

VA Funding	$212,000
Non-VA Funding	$ 80,000
TOTAL	$292,000

EDUCATION:

Regularly scheduled GRECCORMEC Seminar Series.

Regional Conference on Senile Dementia of the Alzheimer Type.

Community Outreach Programs and Cooperative Educational Visits to VAMCs within the GRECC's Medical District.

Geriatric Medicine Rotations.

CLINICAL CARE:

Inpatients	
Consultations	187
Outpatients	
Visits	310

VA MEDICAL CENTER
MINNEAPOLIS, MN
(612) 725-6767

Director:	Daniel E. Cooney
Assistant Director:	Barbara Gallagher
Chief of Staff:	Robert A. Petzel, M.D.

BEDS (FY 81):

	Average Operating Beds	Average Daily Census	Occupancy Rate
Hospital:			
All Sections	738	563	76.3
Psychiatric	99	94	94.9
Surgical	318	213	67.0
Medical Total	321	255	79.4
Medical Intermediate	N/A	N/A	N/A
VA Domiciliary Care	N/A	N/A	N/A
VA Nursing Home Care	N/A	N/A	N/A
Community Nursing Home	N/A	N/A	N/A

PATIENTS TREATED (FY 81):

Inpatients		Outpatients	
VA Hospital	19,255	Medical Visits-Staff	190,102
Nursing Home Care		Dental Staff	
VA	-0-	Exams	1,274
Community	547	Treatment Cases Compl.	943

STAFF - FTEE as of 6/30/82:

2,175.4

BUDGET (FY 82):

$87,316,275

PRIMARY MEDICAL SCHOOL AFFILIATE:

University of Minnesota Medical School

PALO ALTO GRECC

FY 1981

DIRECTOR: Gerald M. Reaven, M.D.

RESEARCH:

Focus is on endocrinology of aging, cognitive and behavioral aspects of aging, cellular biology of aging and health care delivery to the geriatric patient.

GRECC RELATED RESEARCH BUDGET:

VA Funding	$480,000
Non-VA Funding	$538,000
TOTAL	$1,018,000

EDUCATION:

Physician Fellowship Program in Geriatrics.

Interdisciplinary Team Training in Geriatrics Program.

Weekly, bi-monthly and monthly lecture and seminar series for house staff, ITTG students and VAMC staff. Two-day workshop on Team Development.

CLINICAL CARE:

Outpatient Visits/Consults	680

VA MEDICAL CENTER
PALO ALTO, CA
(415) 493-5000

Director:	James C. DeNiro
Assistant Director:	Albert B. Washko
Chief of Staff:	Franklin Ebaugh, Jr., M.D. (Prof. Svcs.) Mark P. Graeber, M.D. (Menlo Park Div.)

THIS IS A TWO DIVISION MEDICAL CENTER — PALO ALTO WHICH IS THE LOCATION OF THE GRECC AND MENLO PARK WHICH IS THE PSYCHIATRIC AND LONG-TERM CARE DIVISION.

ALL FIGURES ARE COMBINED MEDICAL CENTER FIGURES.

BEDS (FY 81):

	Average Operating Beds	Average Daily Census	Occupancy Rate
Hospital:			
All Sections	1,276	1,039	81.4
Psychiatric	736	591	80.3
Surgical	135	97	71.9
Medical Total	405	351	86.7
Medical Intermediate	(224)	(205)	(91.5)
VA Domiciliary Care	N/A	N/A	N/A
VA Nursing Home Care	150	142	94.7
Community Nursing Home	N/A	63	N/A

PATIENTS TREATED (FY 81):

Inpatients		Outpatients	
VA Hospital	12,530	Medical Visits-Staff	184,386
Nursing Home Care		Dental Staff	
VA	462	Exams	477
Community	173	Treatment Cases Compl.	516

STAFF - FTEE as of 6/30/82:

2,506.3

BUDGET (FY 82):

$89,393,680

PRIMARY MEDICAL SCHOOL AFFILIATE:

Stanford University School of Medicine

ST. LOUIS GRECC

FY 1981

DIRECTOR: Bernard B. Davis, M.D.

RESEARCH:

Focus is on cardiopulmonary, biochemistry, alcoholism and aging, psychology and clinical pharmacology.

GRECC RELATED RESEARCH BUDGET:

VA Funding	$147,000
Non-VA Funding	$219,000
TOTAL	$366,000

EDUCATION:

Regularly scheduled geriatrics and gerontology lecture series for VAMC staff and students.

GRECC Visiting Guest Lecture Series.

House staff and medical and associated health profession student rotations through GRECC clinical unit.

CLINICAL CARE:

Inpatients	
Operating Beds	16
Patients Treated	469
Average Daily Census	15.4
Consultations	808
Outpatients	
Consultations	368

VA MEDICAL CENTER
ST. LOUIS, MO
(314) 487-0400

Director: Sidney M. Ford
Assistant Director: Donald L. Ziegenhorn
Chief of Staff: Robert M. Donati, M.D.

THIS IS A TWO DIVISION MEDICAL CENTER — JEFFERSON BARRACKS (JB) WHICH IS THE LOCATION OF THE GRECC AND JOHN COCHRAN (JC) WHICH IS THE ACUTE CARE HOSPITAL.

ALL FIGURES ARE COMBINED MEDICAL CENTER FIGURES.

BEDS (FY 81):

	Average Operating Beds	Average Daily Census	Occupancy Rate
Hospital:			
All Sections	853	682	80.0
Psychiatric	255	210	82.4
Surgical	203	153	75.4
Medical Total	395	319	80.8
Medical Intermediate	N/A	N/A	N/A
VA Domiciliary Care	N/A	N/A	N/A
VA Nursing Home Care	93	90	96.8
Community Nursing Home	N/A	86	N/A

PATIENTS TREATED (FY 81):

Inpatients		Outpatients	
VA Hospital	14,940	Medical Visits-Staff	211,967
Nursing Home Care		Dental Staff	
VA	112	Exams	639
Community	330	Treatment Cases Compl.	645

STAFF - FTEE as of 6/30/82:

2,182.0

BUDGET (FY 82):

$79,292,097

PRIMARY MEDICAL SCHOOL AFFILIATE:

St. Louis University School of Medicine

Washington University School of Medicine

SEATTLE/AMERICAN LAKE GRECC

FY 1981

DIRECTOR: Murray A. Raskind, M.D.

RESEARCH:

Focus on age related changes in behavior and neuroendocrine function and in the interrelationships between these two aspects of aging.

GRECC RELATED RESEARCH BUDGET:

VA Funding	$162,000
Non-VA Funding	$159,000
TOTAL	$321,000

EDUCATION:

GRECC Quarterly Newsletter distributed nationally.

Monthly multidisciplinary seminar series and clinical topics in geriatric teaching program for VAMC staff and students.

Regularly scheduled GRECC visiting lecture series and GRECC research forum.

House staff and associated health profession student rotations through geriatric units.

CLINICAL CARE:

	Seattle	American Lake
Inpatients		
Operating Beds	12	18
Patients Treated	108	22
Average Daily Census	11	18
Consultations	100	N/A
Outpatients		
Visits	839	20

VA MEDICAL CENTER
SEATTLE, WA
(206) 762-1010

Director: Jerome R. Dolezal
Assistant Director: Joan E. Kanyuck
Chief of Staff: Benjamin H. Belknapp, M.D.

BEDS (FY 81):

	Average Operating Beds	Average Daily Census	Occupancy Rate
Hospital:			
All Sections	303	250	82.5
Psychiatric	66	64	97.0
Surgical	98	89	90.8
Medical Total	139	96	69.1
Medical Intermediate	N/A	N/A	N/A
VA Domiciliary Care	N/A	N/A	N/A
VA Nursing Home Care	N/A	N/A	N/A
Community Nursing Home	N/A	105	N/A

PATIENTS TREATED (FY 81):

Inpatients		Outpatients	
VA Hospital	8,364	Medical Visits-Staff	142,118
Nursing Home Care		Dental Staff	
VA	N/A	Exams	179
Community	418	Treatment Cases Compl.	458

STAFF - FTEE as of 6/30/82:

1,038.6

BUDGET (FY 82):

$49,485,440

PRIMARY MEDICAL SCHOOL AFFILIATE:

University of Washington School of Medicine

VA MEDICAL CENTER
AMERICAN LAKE, TACOMA, WA
(206) 582-8440

Director:	William E. Claypool
Assistant Director:	Harrison S. Miller
Chief of Staff:	Carl J. Gerber, M.D.

BEDS (FY 81):

	Average Operating Beds	Average Daily Census	Occupancy Rate
Hospital:			
All Sections	450	370	82.2
Psychiatric	306	259	84.6
Surgical	N/A	N/A	N/A
Medical Total	144	111	76.4
Medical Intermediate	(63)	(61)	(96.8)
VA Domiciliary Care	N/A	N/A	N/A
VA Nursing Home Care	76	72	94.7
Community Nursing Home	N/A	28	N/A

PATIENTS TREATED (FY 81):

Inpatients		Outpatients	
VA Hospital	2,893	Medical Visits-Staff	50,664
Nursing Home Care		Dental Staff	
VA	N/A	Exams	477
Community	61	Treatment Cases Compl.	477

STAFF - FTEE as of 6/30/82:

818.0

BUDGET (FY 82):

$25,425,564

PRIMARY MEDICAL SCHOOL AFFILIATE:

University of Washington School of Medicine

SEPULVEDA GRECC

FY 1981

DIRECTOR: Arthur Cherkin, Ph.D.

RESEARCH:

Focus on Endocrinology, memory, and on fostering inclusion of aging as a variable in new research projects throughout the medical center.

GRECC RELATED RESEARCH BUDGET:

VA Funding	$556,000
Non-VA Funding	$ 8,000
TOTAL	$564,000

EDUCATION:

Physician Fellowship Program in Geriatrics.

Interdisciplinary Team Training in Geriatrics Program.

iatric Rehabilitation Involvement Program with Students (an intergenerational program).

Monthly seminar series for VAMC staff and students.

House staff rotations through geriatric medicine.

CLINICAL CARE:

Inpatients

Operating Beds	27
Patients Treated	93
Average Daily Census	19

Outpatients

Visits	8/week

VA MEDICAL CENTER
SEPULVEDA CA
(213) 894-8271

Director:	Ronald L. Nelson
Assistant Director:	Ralph L. Fullwood
Chief of Staff:	Wiley Barker, M.D.

BEDS (FY 81):

	Average Operating Beds	Average Daily Census	Occupancy Rate
Hospital:			
All Sections	650	457	70.3
Psychiatric	209	159	76.1
Surgical	123	70	56.9
Medical Total	318	228	71.7
Medical Intermediate	(50)	(40)	(80.0)
VA Domiciliary Care	N/A	N/A	N/A
VA Nursing Home Care	200	176	88.0
Community Nursing Home	N/A	82	N/A

PATIENTS TREATED (FY 81):

Inpatients		Outpatients	
VA Hospital	11,734	Medical Visits-Staff	189,672
Nursing Home Care		Dental Staff	
VA	286	Exams	1,096
Community	148	Treatment Cases Compl.	1,172

STAFF - FTEE as of 6/30/82:

1,784.2

BUDGET (FY 82):

$63,084,964

PRIMARY MEDICAL SCHOOL AFFILIATE:

UCLA School of Medicine

APPENDIX F

DEFINITION OF TERMS

GERIATRICS AND GERONTOLOGY ADVISORY COMMITTEE (GGAC): Established through Public Law 96-330, Title III.

GERIATRIC RESEARCH, EDUCATION AND CLINICAL CENTER (GRECC): A specialized center operating within a VA health care facility.

FACILITY: A VA health care facility, such as a medical center or free-standing outpatient clinic.

ADMINISTRATOR OF VETERANS AFFAIRS: The highest administrative official in the VA. The Administrator is appointed by the President.

DEPARTMENT OF MEDICINE AND SURGERY (DM&S): One of three major elements within the VA. The Department is responsible for the administration of health care programs within the VA.

CHIEF MEDICAL DIRECTOR (CMD): The highest administrative official in the Department of Medicine and Surgery.

ASSISTANT CHIEF MEDICAL DIRECTOR (ACMD): The highest administrative official for a specific functional division within the Department of Medicine and Surgery.

GERIATRIC EVALUATION UNIT (GEU): A small clinical in-patient unit operated by GRECC to assess clinical status of geriatric veteran patients.

GERIATRIC FELLOWSHIP PROGRAM: A post-doctoral time-limited clinical experience in geriatrics. Fellowship programs operating at facilities hosting GRECCs are sponsored by the VA or some other identified agency.

FELLOW: A post-doctoral health professional student.

ROTATION: A time-limited clinical experience provided as part of a pre-professional or professional health education program, such as for nursing or psychology students, physician interns or residents, and other health related occupations.

AFFILIATION: An arrangement between a VA health care facility and a university or school through which students receive clinical education and training at the facility.

MEMORANDUM OF UNDERSTANDING: A document outlining the nature of an affiliation and it is signed by a representative from the facility and the university or school.

REGIONAL MEDICAL EDUCATION CENTER (RMEC): A specialized, administratively autonomous center, residing within a VA facility and having responsibility for continuing education programs and activities within a defined geographic location.

DIRECTOR: The chief administrative official of a discrete unit within the VA health care system, such as medical center Director, outpatient clinical Director, GRECC Director, RMEC Director and the like.

CHIEF OF STAFF (COS): The senior medical official in a VA health care facility having responsibility for overseeing the facility's total clinical program.

VA MEDICAL CENTER (VAMC): A health care facility which is composed of a hospital, clinics and it may include a VA Nursing Home Care Unit and/or a Domiciliary.

FREE-STANDING VA OUTPATIENT CLINIC (VAOPC): An independent VA health care facility, unaffiliated with a medical center, which provides outpatient and clinic services to veteran patients.

APPENDIX C

Statistical Tables

Table C-1

DEPARTMENT OF MEDICINE AND SURGERY

Summary Highlights

FY 1982

Facilities operating at end of year -	
Medical Centers	172
Hospital care	(172)
Outpatient care	(172)
Nursing home care	(99).
Domiciliary care	(15)
Independent or satellite clinics	53
Independent domiciliaries	1
Employment (net full-time equivalent)	195,251
Operating costs (in millions)	$7,197.1
Medical care	6,999.4
Research in health care	139.8
Other	57.8
Inpatients treated	1,357,547
VA facilities	1,272,151
Other facilities	85,396
Average daily inpatient census	102,601
VA facilities	80,467
Other facilities	22,134
Outpatient medical visits	17,971,298
VA staff	16,024,008
Fee-basis	1,947,290
Outpatient dental care	
VA staff	
Examinations	159,964
Treatment cases completed	166,352
Cases completed on fee-basis	51,899

Source: Department of Medicine and Surgery, Veterans Administration, 1983

TABLE C-3

OFFICE OF GERIATRICS AND EXTENDED CARE (18B)

PATIENT ACTIVITY ESTIMATES - 1984 BUDGET

Workload	1979 Actual	1980 Actual	1981 Actual	1982 Actual	1983 Budget Estimate	1983 Current Estimate	1988 Estimate
VA NURSING HOME CARE							
Number of Units	92	92	95	97	102	101	124
Beds, End of Year	8,357	8,496	8,973	9,239	9,847	9,769	12,871
Beds, Average	8,212	8,394	8,700	9,125	9,605	9,547	12,578
Admissions	4,428	4,666	5,368	6,530	5,446	6,354	8,412
Discharges	4,190	4,461	4,913	6,003	5,446	6,354	8,412
Patients Treated	12,283	12,750	13,554	15,072	14,522	15,328	20,293
Census	7,760	7,933	8,145	8,486	9,076	8,974	11,881
Service-Connected	2,569	2,721	2,859	2,970	3,177	3,141	4,158
Nonservice-Connected	5,191	5,212	5,286	5,516	5,899	5,833	7,723
% Service-Connected	33.1	34.3	35.1	35.0	35.0	35.0	35.0
Length of Stay	521.3	492.4	488.1	443.5	608.0	443.5	443.5
% Occupancy Rate	94.5	94.5	93.6	93.0	94.5	94.0	94.5
% Turnover Rate	4.5	4.7	5.0	5.9	5.0	5.9	5.9
Per Diem	$65.65	$75.39	$80.84	$87.78	$92.29	$92.83	------

TABLE C-3(A)

OFFICE OF GERIATRICS AND EXTENDED CARE (18B)

PATIENT ACTIVITY ESTIMATES - 1984 BUDGET

Workload	1979 Actual	1980 Actual	1981 Actual	1982 Actual	1983 Budget Estimate	1983 Current Estimate	1988 Estimate
VA DOMICILIARY CARE							
Number of Units	16	16	16	16	16	16	16
Beds, End of Year	9,389	8,486	8,310	8,230	8,270	7,778	5,851
Beds, Average	9,475	9,217	8,390	8,277	8,270	7,778	5,851
Admissions	6,920	6,115	6,571	6,491	7,180	6,700	5,280
Discharges	7,480	6,874	6,814	6,815	7,180	6,700	5,280
Patients Treated	16,541	15,180	14,877	14,535	14,700	13,700	10,780
Census	8,448	7,894	7,353	7,087	7,520	7,000	5,500
Service-Connected	2,441	2,171	2,066	1,984	2,106	1,960	1,540
Nonservice-Connected	6,007	5,723	5,287	5,103	5,414	5,040	3,960
% Service-Connected	28.9	27.5	28.1	28.0	28.0	28.0	28.0
Length of Stay	415.4	480.7	460.9	435.0	461.0	452.0	452.0
% Occupancy Rate	89.2	85.6	87.6	85.6	90.9	90.0	94.0
% Turnover Rate	7.4	7.3	7.7	8.0	8.0	8.0	8.0
Per Diem	$25.64	$29.39	$31.70	$34.70	$36.52	$37.47	-----

TABLE C-3(B)

OFFICE OF GERIATRICS AND EXTENDED CARE (18B)

PATIENT ACTIVITY ESTIMATES - 1984 BUDGET

Workload	1979 Actual	1980 Actual	1981 Actual	1982 Actual	1983 Budget Estimate	1983 Current Estimate	1988 Estimate
STATE HOME NURSING HOME CARE							
Number of Facilities	36	36	38	39	40	41	46
Admissions	4,187	4,797	4,531	4,884	5,503	5,190	5,963
Discharges	3,934	4,346	4,011	4,516	5,503	5,190	5,963
Patients Treated	9,282	10,053	10,085	11,116	12,247	11.934	13,712
Census	5,203	5,586	5,855	6,428	6,744	6,744	7,749
Service-Connected	567	637	720	771	809	809	930
Nonservice-Connected	4,636	4,949	5,135	5,657	5,935	5,935	6,819
% Service-Connected	10.9	11.4	12.3	12.0	12.0	12.0	12.0
Length of Stay	482.7	470.5	532.8	519.5	447.1	474.3	474.3
% Turnover Rate	6.3	6.5	5.7	5.9	6.8	6.4	6.4
Per Diem	$10.13	$10.16	$12.10	$12.10	$12.10	$12.10	------

TABLE C-3(C)

OFFICE OF GERIATRICS AND EXTENDED CARE (18B)

PATIENT ACTIVITY ESTIMATES - 1984 BUDGET

Workload	1979 Actual	1980 Actual	1981 Actual	1982 Actual	1983 Budget Estimate	1983 Current Estimate	1988 Estimate
STATE HOME DOMICILIARY CARE							
Number of Facilities	39	41	41	42	43	43	45
Admissions	5,358	4,631	4,571	4,385	4,552	4,694	5,469
Discharges	5,352	5,095	4,792	4,245	4,552	4,694	5,469
Patients Treated	10,536	9,786	9,302	8,783	9,294	9,550	11,127
Census	5,296	4,892	4,572	4,493	4,742	4,856	5,658
Service-Connected	996	978	956	944	996	1,020	1,188
Nonservice-Connected	4,300	3,914	3,616	3,549	3,746	3,836	4,470
Length of Stay	361.2	351.4	348.2	386.3	380.0	377.6	377.6
% Turnover Rate	8.4	8.7	8.7	7.9	8.0	8.1	8.1
Per Diem	$5.50	$5.50	$6.35	$6.35	$6.35	$6.35	-----

TABLE C-3(D)

OFFICE OF GERIATRICS AND EXTENDED CARE (18B)

PATIENT ACTIVITY ESTIMATES - 1984 BUDGET

Workload	1979 Actual	1980 Actual	1981 Actual	1982 Actual	1983 Budget Estimate	1983 Current Estimate	1988 Estimate
STATE HOME HOSPITAL CARE							
Number of Facilities	8	7	7	7	7	7	7
Admissions	5,200	5,004	4,487	4,037	3,451	2,979	2,979
Discharges	5,206	5,100	4,451	4,047	3,451	2,979	2,979
Patients Treated	6,192	5,994	5,343	4,650	4,090	3,569	3,569
Census	980	929	881	580	639	590	590
Service-Connected	98	105	97	65	70	65	65
Nonservice-Connected	882	824	784	516	569	525	525
% Service-Connected	10.0	11.3	11.0	11.0	11.0	11.0	11.0
Length of Stay	68.7	66.7	72.2	52.3	67.6	72.3	72.3
% Turnover Rate	44.3	45.7	42.1	58.1	45.0	42.1	42.1
Per Diem	$11.50	$10.52	$13.25	$13.25	$13.25	-------	

TABLE C-3(E)

OFFICE OF GERIATRICS AND EXTENDED CARE (18B)

PATIENT ACTIVITY ESTIMATES - 1984 BUDGET

Workload	1979 Actual	1980 Actual	1981 Actual	1982 Actual	1983 Budget Estimate	1983 Current Estimate	1988 Estimate
COMMUNITY NURSING HOME CARE							
Number of Homes	2,901	2,979	3,172	3,200	2,900	3,200	3,200
Admissions	19,925	19,610	20,265	22,635	22,097	21,808	28,821
Discharges	18,971	20,206	18,750	21,076	22,097	21,808	28,821
Patients Treated	27,807	28,536	28,242	31,658	31,492	31,808	42,037
Census	8,126	8,529	8,348	9,525	9,395	10,000	13,216
Service-Connected	3,470	3,992	3,915	4,477	4,416	4,700	6,212
Nonservice-Connected	4,656	4,537	4,433	5,048	4,979	5,300	7,004
% Service-Connected	42.7	46.8	46.9	47.0	47.0	47.0	47.0
Length of Stay	138.4	135.1	137.9	135.4	124.0	136.0	136.0
% Turnover Rate	19.5	19.7	18.7	18.4	19.4	18.2	18.2
Per Diem	$32.72	$36.96	$40.77	$46.21	$54.24	$52.65	-----